STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 06/04/19 through 06/07/19 and 06/10/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/04/19 through 06/07/19 and 6/10/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 6 complaints were investigated during the survey. The census in this 180 certified bed facility was 172 at the time of the survey. The survey sample consisted of 55 current Resident reviews and 8 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		7/24/19

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

Electronically Signed | 06/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to enhance and promote dignity for 7 residents during the dining experience in the Day Room on Unit 2 in the following ways: 1. Meals were served in an institutional manner to Residents on trays. 2. Certified Nursing Assistant #2 (CNA) was	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 550	Continued From page 2 standing with her hands on her hips while feeding a resident. 3. CNA #1, CNA #2, CNA #3 stood while feeding Residents. 4. CNAs placed clothing protectors on Residents without asking their permission. 5. CNA #2 turned off the TV because she felt a resident wasn't eating due to the TV being on. 6. CNA #2 was putting too much food on a spoon to feed a resident and not waiting for the resident to chew and swallow her food before giving her something to drink or eat. The findings included: On 06/07/2019 at approximately 1:08 PM, a Resident's family member approached surveyor in the conference room with concerns that her mother, Resident #124, would be left alone in the Day Room on unit 2 with other residents waiting for their lunch. She stated there was no staff present when she left the Day Room. "My mom need supervision when eating." "I stopped by the nurses station to tell them no staff was in the Day Room." On 06/07/19 at approximately 1:12 PM the surveyor entered the Day Room on Unit 2, there were five residents present with CNA #4 (Certified Nursing Assistant) sitting beside Resident #124, (the resident had received her tray earlier from her daughter who was eating). CNA #4 was interviewed concerning residents sitting in the Day Room. She stated that "I usually get help," "I just can't leave them here unattended." CNA #1 was asked what time are the trays usually delivered to the Day Room? She said "Usually before now."	F 550	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F550 1. Residents receiving meals in the Day Room on Unit 2 are receiving meals removed from trays and with assistance from staff seated at eye level with the residents. Clothing protectors are used with resident permission. The TV will be on per resident preference. Appropriate amounts of food will be offered on the spoon and the resident will be allowed to chew and swallow before being offered other food or drink. Staff will be courteous when interacting with residents. Resident #124 is receiving assistance with meals in a manner which enhances and promotes dignity. 2. Residents will be assisted with the dining experience in a manner to enhance and promote dignity. 3. Nursing staff will be educated on: " Removing meals items from tray when serving residents " Assisting with meals from a seated position to be at eye level with the residents " Requesting permission to use clothing protectors before applying " TV on per resident preference " Appropriate amount of food to be offered with adequate time to chew and swallow before being offered other food or drink " Courteous behavior when interacting with residents " Supervision of Residents during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 550	Continued From page 3 The trays arrived around 1:25 PM for the now six residents who were in the Day Room. Three CNAs were present and handed out trays to the residents. CNA #4 was asked how long does it usually take for the resident's trays to arrive? She stated that the trays are usually here by now but are sometimes late getting here. On 06/07/19 at approximately 1:40 PM, the unit manager was asked to come down to the Day Room on Unit 2 to speak to surveyor; staff were observed standing up while feeding residents. Once Unit Manager, LPN #9 (Licensed Practical Nurse) entered the Day Room, the staff continued to feed resident's standing up. No interventions were made by LPN #9. The following observations were made: Meals were served in an institutional manner to Residents on trays; Certified Nursing Assistant #2 (CNA) was standing with her hands on her hips while feeding a resident; CNA #1, CNA #2, CNA #3 stood while feeding Residents; CNAs placed clothing protectors on Residents without asking their permission; CNA #2 turned off the TV because she felt a resident wasn't eating due to the TV being on; CNA #2 was putting too much food on a spoon to feed a resident and not waiting for the resident to chew and swallow her food before giving her something to drink or eat. On 06/07/19 at approximately 2:06 PM an interview was conducted with Unit Manager, LPN #9. The concerns involving Resident #124 and issues with staff in the Day Room were discussed. LPN #9 said that Resident #124	F 550	mealtimes 4. Nursing Administration will complete a random weekly observation of meals to ensure that resident dining experiences are enhancing and promoting resident dignity. 5. Results of the observations will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 550	Continued From page 4	F 550		

"Daughter will visit her knowing that she needs assistance and will usually sit in the room and wait for staff to get there." "Staff have asked daughter in the past not to leave her in there." "Sometimes the daughter doesn't let staff know when she leaves." "Resident #124 is a very slow eater." LPN #9 was asked what should have been done to ensure the residents were treated with dignity and respect? "The Day Room is an assistive dining area for Residents that need coaxing or feeding." "The Nurse's aide turned off the TV because the Resident was watching it rather than eating." "Everyone had their trays in front of them." "It would look better if they took the trays off." "The CNAs should have sat down and fed them at eye level." "CNA standing with hands on hip was not acceptable." LPN #9 stated it was a "Dignity Issue."

On 06/07/2019 at approximately 2:30 PM interviews were conducted with CNA #1 and CNA #2. They were interviewed separately in the conference room concerning the above issues. CNA #1 stated that she was nervous that she was being looked at in the dining room and would normally not stand while feeding or assisting a resident. When asked if meals should be served on trays CNA #1 stated that "it's okay to keep food on trays for restorative care residents." CNA #2 stated that she didn't realize that she had her hands on her hips while feeding a resident but she usually stands with her hands on her hips at other moments not realizing it. She also said that the resident eats slow so she was putting extra food on her spoon. "I usually keep the meals on the trays because the food stays on their trays when they eat in their rooms." "I realize now that it's a dignity issue."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 550	Continued From page 5 Policy received from Corporate Nurse entitled Meal Delivery: Effective Date: 09/20/18. Policy: Patients will be served meals in a courteous and dignified manner. Procedure: All Patients shall be encouraged to consume meals in the dining room to provide stimulation. The decision will be based upon the patient's medical status and personal preferences. Meal items should be removed from trays in group dining areas. On 06/07/19 at approximately 3:15 PM a pre-exit meeting was conducted with the Nurse Consultant, Director Of Nursing and the Administrator present. The above findings were discussed. No further information was provided by facility staff.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 584	Continued From page 6 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a homelike environment during the dining observation on 06/07/19 in the Day room on unit two. Facility staff served resident meals on trays during the dining observation in the Day Room on unit one for lunch. The findings include: On 06/07/19 at 1:08 p.m., observation of dining in the Day Room was conducted. Seven residents were observed sitting in the activity room waiting for their meals. On 06/07/19 at 1:25 p.m., six residents were	F 584	F584 1. Residents are receiving meals in the Day Room on Unit 2 with meals removed from trays to promote a homelike environment. 2. Residents in all dining rooms will receive meals removed from trays to promote a homelike environment. 3. Nursing staff will be educated on: " Removal of meal items from tray when serving residents to promote a homelike environment 4. Nursing Administration will complete a random weekly observation of meals to ensure that resident meals are served off trays in a homelike environment. 5. Results of the observations will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 584	Continued From page 7 served their meals on trays. On 06/07/19 at approximately 2:06 PM an interview was conducted with LPN #9 (Unit Manager). Who stated "Everyone had their trays in front of them." "It would look better if they took the trays off." LPN #9 stated it was a "Dignity Issue." On 06/07/2019 at approximately 2:30 PM interviews were conducted with CNA #1 and CNA #2. They were interviewed separately in the conference room concerning the above issues: CNA #1 was asked if meals should be served on trays? She stated that "It's okay to keep food on trays for restorative care residents." CNA #2 was asked if meals should be served on trays; she stated that "I usually keep the meals on the trays because the food stays on their trays when they eat in their rooms." "I realize now that it's a dignity issue." Policy received from Corporate Nurse entitled Meal Delivery: Effective Date: 09/20/18. Policy: Patients will be served meals in a courteous and dignified manner. Procedure: All Patients shall be encouraged to consume meals in the dining room to provide stimulation. The decision will be based upon the patient's medical status and personal preferences. Meal items should be removed from trays in group dining areas. On 06/07/19 at approximately 3:15 PM a pre-exit meeting was conducted with the Nurse Consultant, Director Of Nursing and the Administrator was present. The above findings were discussed. No additional information was presented by facility staff.	F 584	presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 9	F 622		

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 10 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to send the required documents for a facility transfer for six of 63 residents in the survey sample, Resident #47, 39, 422, 86, 139, 170, & 86. 1. The facility failed to send Resident #47's comprehensive care plan and/or care plan goals upon transfer to the hospital on 5/6/19. 2. The facility staff failed to send Resident #39's care plan summary to include their goals when discharged to the hospital on 05/10/19. 3. The facility staff failed to send Resident #422's care plan summary to include their goals when discharged to the hospital on 05/22/19. 4. The facility staff failed to send Resident #139's care plan summary goals upon discharge to the hospital on 5/9/19. 5. The facility staff failed to send Resident #170's care plan summary goals upon discharge to the hospital on 5/28/19. 6. The facility staff failed to send Resident #86's care plan summary goals when discharged to the hospital on 03/25/2019.	F 622	F622 1. Residents #47, 39, 422, and 86 are current residents. Resident #139 discharged to home on June 20, 2019. Resident #170 discharged to home on June 22, 2019. 2. Residents discharged/transferred to the hospital during the past month were reviewed to ensure that a copy of their care plan goals was sent to the receiving provider. 3. Nursing staff will be educated on: " Documentation that resident care plan goals were sent at time of discharge/transfer to the hospital 4. The Unit Manager will complete a random weekly review of residents who were discharged/ transferred to the hospital to ensure that there is documentation that the care plan goals were sent to the receiving provider. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 11	F 622		

The findings include:

1. Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to, heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #47's clinical record revealed that she had been transferred to the hospital on 5/6/19. The following nursing note was written: "Resident received and alert and oriented resting in bed @ (at) 2 L (liters). Resident and daughter (Name of Dtgr) was concerned and said she is going to take her to ER (emergency room) to be seen. MD (medical doctor) office was called and made aware of situation will continue to monitor.

The next note dated 5/7/19 documented the following: "Patient admitted for Acute Hypoxic Respiratory Failure."

Further review of the clinical record revealed that she was admitted back to the facility on 5/14/19.

There was no evidence that Resident #47's care plan goals were sent with the resident upon transfer to the hospital.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 12	F 622		

documents were sent with the resident upon transfer to the hospital, LPN #2 stated that the face sheet, medication list, pertinent labs, the bed hold policy and care plan was sent with the resident upon transfer. When asked if Resident #47's care plan was sent with her upon transfer to the hospital on 5/6/19, LPN #2 checked the nursing notes and her INTERACT (Interventions to Reduce Acute Care Transfers) form checklist and stated that she did not see it. LPN #2 stated that there was no way of knowing if these items were sent if it was not documented.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.
No further information was presented prior to exit.
2. Resident #39 was originally admitted to the facility on 04/24/18. Diagnoses for Resident #39 included but not limited to Neuromuscular dysfunction of the bladder.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 03/19/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #39 with dependent of one with bathing, toilet use and transfer, extensive assistance of two with bed mobility, extensive assistance of one with dressing and personal hygiene. In addition, under section H (Bladder and Bowel) was coded for the use of indwelling Foley catheter.

The Discharge MDS assessments was dated for 05/10/19-discharge return anticipated. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 13	F 622		

#39 was re-admitted to the facility on 05/13/19.

On 05/10/19, according to the facility's documentation, Resident #39 was noted with abdominal tenderness, decreased urine output and worsening of chronic pain. Resident #39 was transported to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 05/13/19.

The review of Resident #39's clinical record did not include documentation the care plan was sent during the time of discharge or faxed to the local hospital shortly after discharge. On 06/05/19 at 12:10 p.m., a request was made to the Director of Nursing (DON) and Cooperate Nurse for documentation that Resident #39's care plan was sent at the time of his discharge to the hospital or shortly after his discharge on 05/10/19. On the same day approximately 12:17 p.m., the DON said they were unable to locate documentation in Resident #39's clinical record that the care plan was sent at the time of his discharge to the hospital on 05/10/19. The DON said the nursing staff were educated to send the care plan when a resident is being discharged to the hospital. She said if it is a 911 emergency transport then the care plan could be faxed shortly after to the Emergency Room (ER). She also stated the nurses are to document the care plan was sent or faxed in the resident's clinical record.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 14	F 622		

3. Resident #422 was originally admitted to the facility on 03/27/19. Diagnoses for Resident #422 included but not limited to Benign Prostatic Hyperplasia (BPH).

The current Minimum Data Set (MDS), a PPS 14-day with an Assessment Reference Date (ARD) of 04/10/19 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. In addition, the MDS coded Resident #422 with dependent of one with bathing, extensive assistance of two with toilet use, extensive assistance dressing and limited assistance of one with bed mobility, transfer and personal hygiene. In addition, under section H (Bladder and Bowel) was coded frequently incontinent of bowel and bladder.

The Discharge MDS assessments was dated for 05/20/19-discharge return anticipated. Resident #422 was re-admitted to the facility on 05/22/19.

On 05/20/19, according to the facility's documentation, Resident #422 had a planned discharge to the local hospital for surgery. Resident #422 was re-admitted to the facility on 05/22/19.

The review of Resident #422's clinical record did not include documentation the care plan was sent during the time of discharge or faxed to the local hospital shortly after discharge. On 06/05/19 at 12:10 p.m., a request was made to the Director of Nursing (DON) and Cooperate Nurse for documentation that Resident #422's care plan was sent at the time of his discharge to the hospital or shortly after his discharge on 05/10/19. On the same day approximately 12:17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 15	F 622		

p.m., the DON said they were unable to locate documentation in Resident #422's clinical record that the care plan was sent at the time of his discharge to the hospital on 05/10/19. The DON said the nursing staff were educated to send the care plan when a resident is being discharged to the hospital. She said, if it is a 911 emergency transport then the care plan could be faxed shortly after to the Emergency Room (ER). She also stated the nurses are to document the care plan was sent or faxed in the resident's clinical record.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

4. Resident #139 was a 77 year old admitted originally to the facility on 4/30/19 and readmitted on 5/20/19. resident #139's diagnoses included but were not limited to, Congestive Heart Failure and Chronic Kidney Disease.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Admission 5 Day with an Assessment Reference date (ARD) of 5/27/19. The Brief Interview for Mental Status (BIMS) was an 11 out of a possible 15 indicating Resident #139 was cognitively intact and capable of daily decision making. Resident #139's MDS transmit history was reviewed and is documented as follows:

5/9/2019 Discharge Assessment-Return Anticipated, Unplanned.
5/20/19 Re-Entry from Acute Hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 16	F 622		

Resident #139's Progress Notes were reviewed and are documented in part, as follows:

5/9/2019 at 12:43 P.M.: Change of Condition: CNA (Certified Nursing Assistant) went in to give patient lunch tray. Patient called for nurse, on observation patient had uncontrollable tremors. he stated he could not get warm. NP (Nurse Practitioner) was informed and joined in the room to assess patient. Order received to send patient to Name (hospital). Life Care transported patient at 1400 (2:00 P.M.)

5/9/2019 20:13 P.M. (8:13): Resident admitted to Name (hospital), diagnosis still unknown. Wife in facility to collect his belongings.

On 6/7/19 at 2:32 P.M. an interview was conducted with Unit Manager RN (Registered Nurse) #2 regarding documents that are sent with residents when they go out to the hospital. Unit Manager RN #2 stated, "We send the discharge summary, the history and physical, any labs, progress notes, the bed-hold policy and a copy of the resident's care plan. Then usually we document in the resident's progress notes what we sent and that it was sent with them to the hospital." Unit Manager RN #2 was asked if the above documents were sent with Resident #139 upon discharge to the hospital on 5/9/2018. Unit Manager RN #2 stated, "I don't see where it was documented that the bed-hold policy or the resident's care plan was sent when he was discharged."

On 6/10/19 at 8:23 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Nurse Consultant the above information was shared. Prior to exit no further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 17	F 622		

information was provided.

5. Resident #170 was originally admitted to the facility on 5/16/19 and readmitted on 6/3/19 with diagnoses to include but not limited to, Major Depression and Hypertension.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Admission 5 Day with an Assessment Reference date (ARD) of 5/23/19. The Brief Interview for Mental Status (BIMS) was an 15 out of a possible 15 indicating Resident #170 was cognitively intact and capable of daily decision making. Resident #170's MDS transmit history was reviewed and is documented as follows:

5/28/2019 Discharge Assessment-Return Anticipated, Unplanned.
6/3/19 Re-Entry from Acute Hospital.

Resident #170's Progress Notes were reviewed and are documented in part, as follows:

5/28/19 11:41 A.M.: patient out to ID (Infectious Disease) appointment at 8:50. family provided transportation. family returned to facility with wheelchair stating patient was sent to ER (emergency room) for low blood pressure.

5/28/19 15:08 P.M. (3:08): patient admitted to Name (hospital) with no diagnosis at this time, daughter aware.

On 6/7/19 at 2:32 P.M. an interview was conducted with Unit Manager RN #2 regarding documents that are sent with residents when they go out to the hospital. Unit Manager RN #2 stated, "We send the discharge summary, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 18	F 622		

history and physical, any labs, progress notes, the bed-hold policy and a copy of the resident's care plan. Then usually we document in the resident's progress notes what we sent and that it was sent with them to the hospital." Unit Manager RN #2 was asked if the above documents were sent with Resident #170 upon discharge to the hospital on 5/29/2018. Unit Manager RN #2 stated, "I don't see where it was documented that the bed-hold policy or the resident's care plan was sent when he was discharged."

On 6/10/19 at 8:23 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Nurse Consultant the above information was shared. Prior to exit no further information was provided.

6. Resident #86 was discharged to the hospital on 03/25/2019 and readmitted to the facility on 03/27/2019. Diagnoses included but were not limited to, Dependence on Renal Dialysis and Hypertension.

Resident #86's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/16/2019 coded Resident #86 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #86 as requiring extensive assistance of 1 with bed mobility, transfer, dressing, toilet use and personal hygiene, supervision with set up help only for eating and total dependence of 1 with bathing.

On 06/05/2019 at approximately 10:00 a.m., the Director of Nursing and was asked, "Can you provide documentation that the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 622	Continued From page 19 summary goals were sent with Resident #86 upon discharge to the hospital on 03/25/2019?" On 06/05/2019 at approximately 1:00 p.m., the Director of Nursing stated, "I was unable to find any documentation that the care plan was sent with Resident #86 to the hospital." The Director of Nursing had stated earlier that she had instructed the staff to send the bed hold policy and care plan with residents when discharged to the hospital and to document in the resident's progress note. The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (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	F 625		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 20 (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 resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written bed hold notification for a hospital transfer for seven of 63 residents in the survey sample, Resident #47, 30, 39, 422, 139, 170, & 86, 1. For Resident #47, facility staff failed to provide written bed hold notification for a hospital transfer on 5/6/19. 2. For Resident #30, facility staff failed to provide written bed hold notification for a hospital transfer on 3/1/19. 3. The facility staff failed to provide Resident #39 and/or resident's representative with a written or resident's representative a copy of the bed hold policy when discharged to the hospital on 05/10/19. 4. The facility staff failed to provide Resident #422 and/or resident's representative with a written or resident's representative a copy of the bed hold policy when discharged to the hospital on 05/22/19	F 625	F625 1. Residents #47, 30, 39, 422, and 86 are current residents of the facility. Resident #139 discharged to home on June 20, 2019. Resident #170 discharged to home on June 22, 2019. 2. Residents discharged/transferred to the hospital over the past month were reviewed to ensure a copy of the facility bed-hold and reserve bed payment policy was provided at time of discharge/transfer. 3. Charge Nurses will be educated on: " Sending copy of facility bed-hold and reserve bed payment policy at time of discharge/transfer to the hospital " Documentation that copy of facility bed-hold and reserved bed payment policy at time of discharge/transfer to the hospital was provided to the Resident 4. The Unit Managers will complete a random weekly review of residents discharged/transferred to the hospital to ensure that there is documentation that the written bed-hold and reserve bed payment policy was sent with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 21 5. The facility staff failed to provide Resident #139 and/or resident's representative with a written or resident's representative a copy of the bed hold policy when discharged to the hospital on 5/9/19. 6. The facility staff failed to provide Resident #170 and/or resident's representative with a written or resident's representative a copy of the bed hold policy when discharged to the hospital on 5/28/19. 7. Resident #86 was discharged to the hospital on 03/25/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written bed hold notice. The findings include: 1. Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #47's clinical record revealed that she had been transferred to the hospital on 5/6/19. The following nursing note was written: "Resident received and alert and oriented resting in bed @ (at) 2 L (liters). Resident and daughter (Name of Dtgr) was concerned and said she is going to take her to ER (emergency room) to be	F 625	Resident. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 22	F 625		

seen. MD (medical doctor) office was called and made aware of situation will continue to monitor.

The next note dated 5/7/19 documented the following: "Patient admitted for Acute Hypoxic Respiratory Failure."
Further review of the clinical record revealed that she was admitted back to the facility on 5/14/19.

There was no evidence that written bed hold notification was sent with the resident upon transfer to the hospital.

On 6/6/19 at 4:45 p.m., an interview was conducted with OSM (other staff member) #4, the Director of Admissions. When asked her role when a resident is sent to the hospital for an acute transfer, OSM #4 stated that the bed hold notice is sent with the resident upon transfer to the hospital. OSM #4 stated that to her knowledge nursing sends the bed hold policy. OSM #4 stated that she will then follow up with the resident and/or responsible party (RP) to see if they would like the bed held. OSM #4 stated that she will follow up with the resident/(RP) 24 hours after transfer.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2 , the unit manager. When asked what documents were sent with the resident upon transfer to the hospital, LPN #2 stated that the face sheet, medication list, pertinent labs, the bed hold policy and care plan was sent with the resident upon transfer. When asked if the bed hold policy was sent with Resident #47 upon transfer to the hospital, LPN #2 checked the nursing notes and her INTERACT (Interventions to Reduce Acute Care Transfers) form checklist and stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 23	F 625		

she did not see it. LPN #2 stated that there was no way of knowing if these items were sent if it was not documented.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.
No further information was presented prior to exit.

2. Resident #30 was admitted to the facility on 6/30/2003 and readmitted on 3/8/2019 with diagnoses that included but were not limited to urinary tract infection, syncope and collapse, and atrial fibrillation. Resident #30's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/15/19. Resident #30 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #30's clinical record revealed that she had been transferred to the hospital on 3/1/19 for syncope and collapse. The following note was written on 3/4/19: "Patient went out to the hospital on 3/1/19. Notice of transfer/dc (discharge) was written up and mailed out to her son on 3/4/19."

Review of Resident #30's notice of transfer/dc dated 3/4/19 did not evidence a written bed hold policy.

Review of Resident #30's INTERACT (Interventions to Reduce Acute Care Transfers) form dated 3/1/19 did not evidence that the written bed hold notification was sent with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 24	F 625		

resident upon transfer to the hospital.

Further review of Resident #30's clinical record revealed that she was admitted back to the facility on 3/8/19.

On 6/5/19 at 4:15 p.m., an interview was conducted with Resident #30. Resident #30 stated that she could not remember receiving a bed hold policy because she was unconscious.

On 6/6/19 at 4:45 p.m., an interview was conducted with OSM (other staff member) #4, the Director of Admissions. When asked her role when a resident is sent to the hospital for an acute transfer, OSM #4 stated that the bed hold notice is sent with the resident upon transfer to the hospital. OSM #4 stated that to her knowledge nursing sends the bed hold policy. OSM #4 stated that she will then follow up with the resident and/or responsible party (RP) to see if they would like the bed held. OSM #4 stated that she will follow up with the resident/(RP) 24 hours after transfer.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2 , the unit manager. When asked what documents were sent with the resident upon transfer to the hospital, LPN #2 stated that the face sheet, medication list, pertinent labs, the bed hold policy and care plan was sent with the resident upon transfer. When asked if the bed hold policy was sent with Resident #30 upon transfer to the hospital, LPN #2 checked the nursing notes and her INTERACT (Interventions to Reduce Acute Care Transfers) form checklist and stated that she did not see it. LPN #30 stated that there was no way of knowing if these items were sent if it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 25	F 625		

was not documented.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.
No further information was presented prior to exit.

3. Resident #39 was originally admitted to the facility on 04/24/18. Diagnoses for Resident #39 included but not limited to, Neuromuscular dysfunction of the bladder.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 03/19/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for 05/10/19-discharge return anticipated. Resident #39 was re-admitted to the facility on 05/13/19.

On 05/10/19, according to the facility's documentation, Resident #39 was noted with abdominal tenderness, decreased urine output and worsening of chronic pain. Resident #39 was transported to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 05/13/19.

The review of Resident #39's clinical record did not include documentation that the bed hold policy was issued during the time of discharge or faxed to the local hospital shortly after discharge.
On 06/05/19 at 12:10 p.m., a request was made to the Director of Nursing (DON) and Cooperate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 26	F 625		

Nurse for documentation that Resident #39 was issued the bed hold policy at the time of his discharge to the hospital or shortly after his discharge on 05/10/19. On the same day approximately 12:17 p.m., the DON said they were unable to locate documentation in Resident #39's clinical record that the bed hold policy was issued at the time of his discharge to the hospital on 05/10/19. The DON said the nursing staff were educated to send the bed hold policy when a resident is being discharged to the hospital but if it is a 911 emergency transport then the bed hold policy could be faxed shortly after to the Emergency Room (ER). She also stated the nurses are to document the bed hold policy was sent or faxed in the resident's clinical record.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

4. Resident #422 was originally admitted to the facility on 03/27/19. Diagnosis for Resident #422 included but not limited to Benign Prostatic Hyperplasia (BPH).

The current Minimum Data Set (MDS), a PPS 14-day with an Assessment Reference Date (ARD) of 04/10/19 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment.

The Discharge MDS assessments was dated for 05/20/19-discharge return anticipated. Resident #422 was re-admitted to the facility on 05/24/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 27	F 625		

On 05/20/19, according to the facility's documentation, Resident #422 had a planned discharge to the local hospital for surgery. Resident #422 was readmitted to the facility on 05/24/19.

The review of Resident #422's clinical record did not include documentation that the bed hold policy was issued during the time of discharge or faxed to the local hospital shortly after discharge. On 06/05/19 at 12:10 p.m., a request was made to the Director of Nursing (DON) and Cooperate Nurse for documentation that Resident #422 was issued the bed hold policy at the time of his discharge to the hospital or shortly after his discharge on 05/10/19. On the same day approximately 12:17 p.m., the DON said they were unable to locate documentation in Resident #422's clinical record that the bed hold policy was issued at the time of his discharge to the hospital on 05/10/19. The DON said the nursing staff were educated to send the bed hold policy when a resident is being discharged to the hospital but if it is a 911 emergency transport then the bed hold policy could be faxed shortly after to the Emergency Room (ER). She also stated the nurses are to document the bed hold policy was sent or faxed in the resident's clinical record.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

5. Resident #139 was a 77 year old admitted originally to the facility on 4/30/19 and readmitted on 5/20/19. Resident #139's diagnoses included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 28	F 625		

but were not limited to, Congestive Heart Failure and Chronic Kidney Disease.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Admission 5 Day with an Assessment Reference date (ARD) of 5/27/19. The Brief Interview for Mental Status (BIMS) was an 11 out of a possible 15 indicating Resident #139 was cognitively intact and capable of daily decision making. Resident #139's MDS transmit history was reviewed and is documented as follows:

5/9/2019 Discharge Assessment-Return Anticipated, Unplanned.
5/20/19 Re-Entry from Acute Hospital.

Resident #139's Progress Notes were reviewed and are documented in part, as follows:

5/9/2019 at 12:43 P.M.: Change of Condition: CNA (Certified Nursing Assistant) went in to give patient lunch tray. Patient called for nurse, on observation patient had uncontrollable tremors. he stated he could not get warm. NP (Nurse Practitioner) was informed and joined in the room to assess patient. Order received to send patient to Name (hospital). (Name of Transport company) transported patient at 1400 (2:00 P.M.)

5/9/2019 20:13 P.M. (8:13): Resident admitted to Name (hospital), diagnosis still unknown. Wife in facility to collect his belongings.

On 6/7/19 at 2:32 P.M. an interview was conducted with Unit Manager RN #2 regarding documents that are sent with residents when they go out to the hospital. Unit Manager RN #2 stated, "We send the discharge summary, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 29	F 625		

history and physical, any labs, progress notes, the bed-hold policy and a copy of the resident's care plan. Then usually we document in the resident's progress notes what we sent and that it was sent with them to the hospital." Unit Manager RN #2 was asked if the above documents were sent with Resident #139 upon discharge to the hospital on 5/9/2018. Unit Manager RN #2 stated, "I don't see where it was documented that the bed-hold policy or the resident's care plan was sent when he was discharged."

On 6/10/19 at 8:23 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Nurse Consultant the above information was shared. Prior to exit no further information was provided.

6. Resident #170 was originally admitted to the facility on 5/16/19 and readmitted on 6/3/19 with diagnoses to include but not limited to Major Depression and Hypertension.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Admission 5 Day with an Assessment Reference date (ARD) of 5/23/19. The Brief Interview for Mental Status (BIMS) was an 15 out of a possible 15 indicating Resident #170 was cognitively intact and capable of daily decision making. Resident #170's MDS transmit history was reviewed and is documented as follows:

5/28/2019 Discharge Assessment-Return Anticipated, Unplanned.
6/3/19 Re-Entry from Acute Hospital.

Resident #170's Progress Notes were reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 30	F 625		

and are documented in part, as follows:

5/28/19 11:41 A.M.: patient out to ID (Infectious Disease) appointment at 8:50. family provided transportation. family returned to facility with wheelchair stating patient was sent to ER (emergency room) for low blood pressure.

5/28/19 15:08 P.M. (3:08): patient admitted to Name (hospital) with no diagnosis at this time, daughter aware.

On 6/7/19 at 2:32 P.M. an interview was conducted with Unit Manager RN #2 regarding documents that are sent with residents when they go out to the hospital. Unit Manager RN #2 stated, "We send the discharge summary, the history and physical, any labs, progress notes, the bed-hold policy and a copy of the resident's care plan. Then usually we document in the resident's progress notes what we sent and that it was sent with them to the hospital." Unit Manager RN #2 was asked if the above documents were sent with Resident #170 upon discharge to the hospital on 5/29/2018. Unit Manager RN #2 stated, "I don't see where it was documented that the bed-hold policy or the resident's care plan was sent when he was discharged."

On 6/10/19 at 8:23 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Nurse Consultant the above information was shared. Prior to exit no further information was provided.

7. Resident #86 was discharged to the hospital on 03/25/2019 and readmitted on 03/27/2019. Diagnoses included but were not limited to,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 31 Dependence on Renal Dialysis and Hypertension. Resident #86's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/16/2019 coded Resident #86 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 06/05/2019 at approximately 10:00 a.m., the Director of Nursing and was asked, "Can you provide documentation that the Bed Hold Notice was sent with Resident #86 upon discharge to the hospital on 03/25/2019?" On 06/05/2019 at approximately 1:00 p.m., the Director of Nursing stated, "I was unable to find any documentation that the Bed Hold policy was sent with Resident #86 to the hospital." The Director of Nursing had stated earlier that she had instructed the staff to send the bed hold policy and care plan with residents when discharged to the hospital and to document in the resident's progress note. The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 32	F 645		

or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 33 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 1 resident (Resident #148) of 63 residents in the survey sample, had a Preadmission Screening and Resident Review (PASRR). The findings included: Resident #148 was admitted to the facility on 05/08/2019. Diagnoses included but were not limited to, Diffuse Large B-Cell Lymphoma, unspecified site and Type 2 Diabetes Mellitus. Resident #148's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/22/2019 was coded with a BIMS (Brief Interview of Mental Status) score of	F 645	F645 1. Resident #148 had a PASRR completed on June 8, 2019. 2. All residents have a completed PASRR. 3. Discharge Planners will be educated on: " Ensuring that a PASRR is available or completed for residents 4. The Discharge Planners will complete a random weekly review of newly admitted residents to ensure that a PASRR is available. 5. Results of the review will be presented to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 34 05 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #148 as requiring extensive assistance of 1 for eating and dressing, extensive assistance of 2 for bed mobility, transfer and toilet use and total dependence of 1 for personal hygiene and bathing. On 06/06/2019 at approximately 4:40 p.m., an interview was conducted with the Social Worker and she was asked, "Does Resident #148 have a PASRR level 1?" The Social Worker stated, "No, I was told that residents who came in to the facility short term did not need a PASRR. I now know that one needs to be completed." The Administrator, Director of Nursing and the Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.	F 645	Committee for review and recommendation. 6. Completion date: July 24, 2019	
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	F 656		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 35 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a comprehensive person-centered care plan for 1 resident (Resident #148) of 63 residents in the survey sample. The facility staff failed to develop a comprehensive person-centered care plan to include Diabetes Mellitus for Resident #148. The findings included:	F 656	F656 1. Resident #148□s care plan was revised to include a plan of care to address diabetes mellitus. 2. Residents with a diagnosis of diabetes mellitus were reviewed to ensure a care plan is present to address diabetes mellitus. 3. Charge Nurses and Interdisciplinary Team will be educated on:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 36 Resident #148 was admitted to the facility on 05/08/2019. Diagnoses included but were not limited to, *Type 2 Diabetes Mellitus and Diffuse Large B-Cell Lymphoma, unspecified site. Resident #148's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 05/22/2019 coded the resident with a BIMS (Brief Interview of Mental Status) score of 05 indicating severe cognitive impairment. In addition, the MDS coded Resident #148 as requiring extensive assistance of 1 for eating and dressing, extensive assistance of 2 for bed mobility, transfer and toilet use and total dependence of 1 for personal hygiene and bathing. Resident #148's MDS was also coded for the usage of Insulin. Section N on the MDS under Insulin read as follows: Insulin Injections-Record the number of days that insulin injections were received during the last 7 days. The MDS was coded for receiving insulin for 7 days. The review of Resident Physician Order Summary indicated the following insulin order: *Toujeo SoloStar Solution Pen-Injector 300 Unit/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for DM (Diabetes Mellitus). The review of Resident #148's comprehensive care plan did not include a care plan for Diabetes Mellitus with the use of insulin, a diabetic medication. On 06/07/2019 at 2:30 p.m., an interview was conducted with the Registered Nurse (RN) #4, MDS Coordinator, and she was asked, "Does Resident #148 have a diagnosis of Diabetes?"	F 656	" Care plan to address diabetes mellitus " Development of person-centered care plan 4. Nursing Administration will complete a random weekly review of care plans to ensure a person-centered plan of care is present. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 37	F 656		

RN #4 stated, "Yes." RN #4 was asked, "Is Diabetes addressed in Resident #148's care plan?" RN #4 stated, "No." RN #4 was asked, "Should his diagnosis of Diabetes be included in his care plan?" RN #4 stated, "Yes, I will put it in now." RN #4 was asked, "What is the purpose of the care plan?" RN #4 stated, "To guide what the plan of care is for the resident."

The Administrator, Director of Nursing and the Nurse Consultant was informed of the findings on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.

Definitions:

* Type 2 Diabetes Mellitus - Diabetes means your blood glucose, or blood sugar, levels are to high. With Type 2 diabetes, the more common type, your body does not make or use insulin well. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. Overtime, high blood glucose can lead to serious problems with your heart, eyes, kidneys, nerves, and gums and teeth.
(https://medlineplus.gov/diabetes.html)

* Toujeo SoloStar Solution Pen-Injector 300 Unit/ML (Insulin Glargine) - Toujeo is the brand name for Insulin glargine. Insulin glarine is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes.
(https://medlineplus.gov/druginfo/meds/a600027.html)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the care plan for three of 63 residents in the survey sample, Residents #47, 35 and 78. 1. For Resident #47, facility staff failed to review and revise the care plan when she acquired two	F 657	F657 1. Resident #47□s care plan was revised to address the resolved blisters. Resident #35□s care plan was revised to address COPD and use of oxygen. Resident #78□s care plan was revised to include release of the wheelchair seat belt. 2. Resident care plans were reviewed to	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 39	F 657		

blisters to her right medial and dorsum foot on 5/17/19, when the blisters had opened with a new treatment order, and when the blisters had resolved.

2. For Resident #35, facility staff failed to revise his care plan with a new diagnosis of COPD (chronic obstructive pulmonary disease) and his new order for oxygen.

3. The facility staff failed to revise the comprehensive care plan to to include how often to release a wheel chair seat belt used for Resident #78.

The findings include:

1. Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #47's clinical record revealed that she had been hospitalized for acute hypoxic respiratory failure and arrived back to the facility on 5/14/19. The admission nursing note dated 5/14/19 documented in part, the following: Skin clear of open areas and intact."

Review of Resident #47's clinical record revealed an initial skin and wound evaluation assessment for blisters to her right medial and dorsum foot

ensure that the care plans are comprehensive and address resident needs.
3. Charge Nurses will be educated on:
" Revision of the care plan to ensure a comprehensive plan of care to meet the resident□s needs
4. Nursing Administration will complete a weekly review of care plans to ensure that the care plans are comprehensive and address resident needs.
5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.
6. Completion date: July 24, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 40	F 657		

(top of foot). The following was documented on the skin assessment for her right medial foot:

"5/17/19
Type: Blister
Location: Right Medial Foot
Present on Admission
1. Area: 14.9 cm2 (centimeters squared) Length: 6.5 cm Width: 3.5 cm Depth: Not Applicable. Exudate: none...Edema: Pitting edema extends > (greater) than 4 cm (centimeters) around wound. Primary Dressing: None. Additional Care: None. (Name of NP (nurse practitioner)) notified."

The following was documented on the skin assessment for her dorsum foot:

5/17/19
Type: Blister
Location: Dorsum Right Foot
Present on Admission
1. Area 5.0 cm2 Length: 3.4 cm x Width: 2.1 cm Depth: Not Applicable. Exudate: none...Edema: Pitting edema extends > (greater) than 4 cm (centimeters) around wound. Goals of Care: Monitor/Manage: wound healing not achievable due to underlying condition.
Treatment: none. Additional Care: None. (Name of NP (nurse practitioner)) notified."

Further review of the weekly skin assessments revealed an assessment dated 5/22/19. This assessment documented Resident #47's blisters as "resolved" on 5/22/19.

Review of a note from the Nurse Practitioner (NP) dated 5/23/19 documented the following: "Patient seen today status post hospitalization and for follow-up weight gain /CHF (congestive heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 41	F 657		

failure), open areas to right foot...This is a 77 year old female who was admitted to the hospital secondary to altered mental status with confusion. According to the patient's daughter who was present at bedside it appeared that the patient was noted to be hypoxic (not receiving enough oxygen) with elevated blood pressures...On further questioning patient has also been noted to have worsening lower extremity edema (swelling)... Hospitalization was further complicated by development of acute diastolic CHF exacerbation requiring IV (intravenous) Lasix (1) with improvement of her symptoms. Due to her lower extremity edema she underwent PVL (Peripheral Vascular Laboratory) (2) which were positive for acute right lower extremity DVT (deep venous thrombosis) (3) for which she was started on Eliquis (4)...5/23/19. Patient seen today for follow-up post hospitalization for open area right...She has blisters to her right dorsal foot per staff. Skin was applied in last 24 hours. This a.m. noted open ulcers with pink wound bed. No drainage noted. She has moderate edema to both her extremities. I have given orders for Xeroform (5) and dry dressing to the daily staff should ACE (6) wrap both extremities daily. I have educated patient not to wear footwear until wounds are resolved.

Review of Resident #47's June 2019 POS (physician order summary) revealed a current physician's order initiated on 5/23/19. The following order was documented: "Clean right foot ulcers with NS (normal saline), pat dry, apply Xerofoam (sic) and civer (sic) with dry dressing and kerlix (dry bandage roll) daily and prn (as needed) if soiled. Do not wear shoes, only grip socks until ulcer heals."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 42	F 657		

Review of Resident #47's comprehensive care plan with revisions dated 5/14/19 failed to evidence that it was updated to reflect the blisters to her right medial and dorsum foot, failed to reflect when the blisters had opened and a treatment order was obtained, and failed to reflect when the blisters were healed.

On 6/6/19 at 11:29 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #47's nurse. When asked the process if a new skin area is found on a resident such a wound, LPN #6 stated that she will do an assessment and measure and stage the wound. LPN #6 stated that they have an electronic device that helps with measuring and staging. LPN #6 stated that they would then notify the medical doctor and obtain orders for treatment. LPN #6 stated that those orders get put into the computer system and then will show up on the MARS and/or TARS to alert nursing staff to complete those treatments. When asked how often wounds are assessed, LPN #6 stated that nurses look at the wounds every day during the dressing change but that the staff do weekly measurements on wounds. LPN #6 then added that staff even do this process for blisters. LPN #6 stated that skin/wound assessments are documented under the assessment tab in PointClickCare (electronic record). When asked if Resident #47 had any pressure areas to her feet; LPN #6 stated that she had blisters but that the blisters were from her fluid overload and edema, not pressure. LPN #6 stated that they were not classifying her blisters as pressure. When asked if she still had blisters to her right foot, LPN #6 stated, "They are resolved." When asked when the blisters resolved, LPN #6 looked at the 5/22/19 skin assessment and stated, "I think 5/22." When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 43	F 657		

asked why the nurse practitioner would then write an order on 5/23/19 for a treatment to the blisters, LPN #6 stated, "No, it must have been found on 5/22/19 and then it opened and we got an order and it was resolved on 5/24." When asked where she was getting that the blisters had resolved on 5/24/19 if there was a current order for treatments to be done, LPN #6 stated that the order should have been discontinued. LPN #6 then stated, "Let me look into this. This doesn't make sense." LPN #6 and LPN #2, the unit manager were then asked to show this writer a timeline of when the blisters were found, when they had opened and when the blister had officially been resolved. At this time LPN #6 had discontinued the current Xeroform order.

On 6/6/19 at 3:00 p.m., an interview was conducted with LPN #2, the unit manager. LPN #2 stated that on 5/17/19 both blisters were found to the right medial and dorsum foot. LPN #7 stated that the staff were to monitor the areas and no treatments orders were given. LPN #2 stated that on 5/22, the fluid seeped out of the blisters leaving leathery skin behind but at this point the blisters were not opened. LPN #2 stated that this is when staff documented the blisters as healed. LPN #2 stated the the nurse practitioner had seen Resident #47 on 5/23/19 and had noticed the two blisters turned into one big open area. LPN #2 stated that this is when the NP wrote orders for the Xeroform treatment. When asked if nursing documented an assessment of the open area including measurements etc., LPN #2 stated that she couldn't find an assessment. LPN #2 could not determine when the open area officially healed. An assessment could not be found in the clinical record. LPN #2 also clarified that the blisters were not classified as pressure areas due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44	F 657		

to the resident's pitting edema and DVT in her right lower leg. When asked LPN #2 the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to determine patient goals, interventions and diagnoses for each resident. When asked if it was important that it was accurate, LPN #2 stated that it was. When asked who was responsible for updating the care plan, LPN #2 stated that any nurse can. When asked if the care plan was updated for any new skin issue, LPN #2 stated that it was. When asked if Resident #47's care plan should have reflected her blisters, new treatment orders and when it resolved, LPN #2 stated, "That should have been there." LPN #2 confirmed that Resident #47's care plan was never revised to reflect her blisters, when it had opened with the new treatment order and when it resolved.

On 6/6/19 at 4:15 p.m., observation was conducted of Resident #47's foot. The blisters to her right foot were healed.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

Facility policy titled, "Care Planning," documents in part, the following: "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment."

(1) Lasix used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45	F 657		

from Davis's Drug Guide for Nurses, 11th edition, p. 587.
(2) PVL "is an ultrasound that looks at blood flow in the major arteries and veins in the limbs. This is used to detect PVD (peripheral vascular disease) or disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood." This information was obtained from The National Institutes of Health. https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease.
(3) DVT-" is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh." This information was obtained from The National Institutes of Health. https://medlineplus.gov/deepveinthrombosis.html.
(4) Eliquis-is indicated for the treatment of DVT (blood clot). This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e9481622-7cc6-418a-acb6-c5450daae9b0.
(5) Xeroform- Petrolatum dressing used to cover and protect low to non-exudating wounds. This information was obtained from https://www.performancehealth.com/xeroform-5x9.
(6) ACE wrap- compression bandage used to reduce swelling and provide support. This information was obtained from https://www.acebrand.com/3M/en_US/ace-brand/.

2. Resident #35 was admitted to the facility on 5/2/17 and readmitted on 5/21/19 with diagnoses that included but were not limited to stroke,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 46	F 657		

paralysis of the left side of the body, heart disease, and COPD (chronic obstructive pulmonary disease). Resident #35's most recent comprehensive MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 3/14/19. Resident #35 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #35's clinical record revealed that he was transferred to the hospital on 5/15/19 and readmitted back to the facility on 5/21/19. The following nursing note documented in part, the following on 5/21/19: "Resident returned to facility via medical transport @ (at) 2:02 (P.M.) Discharge DX (diagnoses): ....COPD exacerbation."

Review of Resident #35's June 2019 POS (physician order summary) documented the following order: "Oxygen therapy-Oxygen at 2 liters per minute via nasal cannula as needed for SOB (shortness of breath)." This order was initiated on 5/21/19.

Review of Resident #35's comprehensive care plan dated 5/23/17 and revised 5/21/19 failed to evidence that it was updated to reflect his diagnosis of COPD exacerbation and current physician's order for supplemental oxygen as needed at 2 liters.

On 6/6/19 at 3:00 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked LPN #2 the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to determine patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47	F 657		

goals, interventions and diagnoses for each resident. When asked if it was important that it was accurate, LPN #2 stated that it was. When asked who was responsible for updating the care plan, LPN #2 stated that any nurse can. When asked if Resident #35 was still to receive supplemental oxygen on an as needed basis, LPN #2 confirmed that his order was current and that he had arrived to the hospital with a diagnoses of COPD. When asked if she could find oxygen on his care plan, LPN #2 stated that it should be part of his respiratory care plan. LPN #2 then confirmed that Resident #35 did not have a current respiratory care plan that reflected his diagnosis of COPD and use for supplemental oxygen.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

3. Resident #78 was admitted to the facility on 10/15/1998. Diagnosis included but were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48	F 657		

limited to, Cerebral Palsy and Autistic Disorder. Resident #78's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 01/14/2019 coded Resident #78 with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #78 as requiring total dependence of 2 with transfers and total dependence of 1 for bed mobility, dressing, eating, toilet use, personal hygiene, bathing and locomotion on unit.

Resident #78's comprehensive care plan was reviewed on 06/10/2019 and revealed that the resident has a seat belt as an Assistive Device. The Focus area on the comprehensive care plan read as follows: "The resident is at risk for falls R/T (Related To) unaware of safety needs, confusion, spastic movements." Review of the Interventions area of the comprehensive care plan read as follows: "Assistive Devices: closed safety bed with concave mattress, high-back wheelchair with ischial step cushion, SEAT BELT, bilateral arm rolls, lateral supports calf board/foot pad."

On 06/10/2019 at 5:25 p.m., an interview was conducted with the Director of Nursing and she was asked, "Can Resident #78 remove his seat belt?" The DON stated, "No." The DON was asked, "Is the seat belt a restraint?" The DON stated, "No. He was assessed and the seat belt was determined to be an assistive device. Resident #78 has Cerebral Palsy and has spastic movements. The seat belt was not be considered to be restrictive." The DON was asked, "Who assessed Resident #78?" The DON stated, "He was assessed by nursing." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 49 DON was asked, "How often should he be repositioned?" The DON stated, "Every 2 hours." The DON was asked, "Should that be care planned?" The DON stated, "Yes." The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interviews, facility document review, and clinical record review, the facility staff failed to follow professional standards of nursing practices for 3 out of 63 residents (Residents #99, 421 and 47). 1. The facility staff failed to follow the physician orders for the administration of Ted hose for Resident #99. 2. The facility staff failed to obtain daily weights per physician orders starting on 06/06/19 for Resident #421. 3a. For Resident #47, facility staff failed to notify the physician for weight gain greater than 2 pounds on 5/29/19 per physician's order.	F 658	F658 1. Resident #99□s order for TED hose was discontinued on June 18, 2019. Resident #421 is being weighed as ordered. Resident #47□s weight was reviewed by the Nurse Practitioner on June 11, 2019. The blisters on Resident #47□s foot resolved on June 6, 2019. 2. Residents with physician orders for TED hose were reviewed to ensure that orders are being followed. Residents with orders for daily weights were reviewed to ensure that the weights are documented. Residents with orders to notify the physician of weight gain greater than 2 pounds were reviewed to ensure that the notification was documented. Residents	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 50 3b. For Resident #47, facility staff failed to accurately assess blisters to her right foot and implement a physician ordered treatment. The findings included: 1. Resident #99 was admitted to the facility on 12/31/17. Diagnoses for Resident #99 included but not limited to *Type II Diabetes, *Congestive Heart Failure, *Edema and *Embolism. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 04/24/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #99 total dependence of one with transfer, dressing, toilet use and personal hygiene, extensive assistance of two with bed mobility and extensive assistance of one with Activities of Daily Living care. On 06/04/19 at 4:12 p.m., Resident #99 was observed lying in bed watching television. During the observation, resident had his feet out of the covers, edema (swelling) was observed to his bilateral lower extremities; Ted hose (compression stockings) were not on his lower extremities. On 06/05/19 at approximately 10:23 a.m., the resident was in bed watching television; feet uncovered; bilateral lower extremities remained with edema; Ted hose not on lower extremities. On 06/06/19 at approximately 11:05 a.m., Resident #99 was observed in bed watching television without Ted hose applied to bilateral lower extremities. On the same day at 11:06 a.m., an interview was conducted with Resident #99. The surveyor asked, "When are your Ted	F 658	with blisters to the skin were reviewed for accurate assessment and completion of physician ordered treatments. 3. Charge Nurses will be educated on: " Following physician orders for TED hose " Following physician orders for obtaining weights " Following physician orders for notifying the MD of weight gain as specified " Assessment of blisters " Implementation and documentation of ordered treatments 4. Nursing Administration will complete a random weekly review of documentation of physician orders and assessment of blisters to ensure that physician orders are implemented and that blisters are accurately assessed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 51	F 658		

hose stockings applied to your legs" he stated, "No one has ever put any stocking to my legs."

The review of Resident #99's Physician Order Sheet for June 2019 revealed the following order: -Ted hose to lower extremity bilateral and daily for times a day for lower extremity edema with an order date of 01/26/18 and starting on 01/27/18. The review of Resident #39's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for June 2019, did not include the order for the Ted hose to be applied to bilateral lower extremities daily.

On 06/06/19 at approximately 4:30 p.m., a request was made to the Director of Nursing (DON) and Cooperate Nurse for a copy of Resident #99's June 2019's TAR. On the same day at approximately 4:43 p.m., an interview was conducted with the DON and Cooperate Nurse in the DON's office. The Cooperate Nurse said the nurse who put the Ted hose order in the computer is no longer employed here. She said the nurse did not transcribe the order correctly; she did not schedule the treatment. The Cooperate Nurse said the order was not put in computer as a medication or treatment but instead it was put in as "other." She said by the nurse putting the order in as other; the Ted hose order will only show up on the Physician Order Form but it will not show up on the TAR or MAR. She said the nurses had no way of knowing the order was ever written.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 52	F 658		

about the findings.

Definitions:
*Ted hose are stockings that help prevent blood clots and swelling in your legs (https://www.drugs.com/cg/ted-hose.html).

*Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

*Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema (mayoclinic.org).

*Edema is swelling caused by excess fluid trapped in the body's tissues. Although edema can affect any part of the body, you may notice in it more in the hands, arms, feet, ankles and legs (mayoclinic.org).

*Embolism is an abnormal condition in which a blood clot travels through the bloodstream and becomes lodged in a blood vessel (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th edition).

2. Resident #421 was admitted to the facility on 05/30/19. Diagnoses for Resident #421 included but not limited to, *End Stage Renal Disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 53	F 658		

(ESRD) (Chronic irreversible kidney failure).

The resident's Minimum Data Set (MDS) assessment was not due. The Admission Assessment completed on 05/30/19 included the following: alert to person, place, time and situation with intact cognition.

The review of Resident #421's Physician Order Sheet for June 2019 revealed the following order: 1). Fluid Restriction: 1500 ml/24 hours every shift. Dining services to provide 1080 ml divided among three meals trays. Nursing to provide 120 ml each shift starting on 06/04/19.

2). Daily weight: notify MD if greater than 2 pounds weight gain in 24 hours every day shift for *Congestive Heart Failure for 30 days starting on 06/06/19.

The review of Resident #421's Medication Administration Record (MAR) revealed a missing weight for 06/08/19. On the same day, the clinical record was reviewed with no documentation for weight being obtained on 06/08/19.

An interview was conducted with RN-Clinical Manager on Unit 3 on 06/10/19 at approximately 5:19 p.m. The UM reviewed the clinical record for 06/08/19 and was unable to locate a weight. The UM stated, "If it is not documented then I can't say it was done." The UM reviewed the units communication report sheet then stated, "Resident #421's room number is not listed for the Certified Nursing Assistant (CNA's) to get his weight." She said if the room number is not written under the weight section on the communication form then the CNA's is not aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 54	F 658		

the weights need to be done.

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

Definitions:

*Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema (mayoclinic.org).
3a. For Resident #47, facility staff failed to notify the physician for weight gain of greater than 2 pounds on 5/30/19 per physician's order.

Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to, heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #47's June 2019 POS (physician order summary) revealed the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 55	F 658		

order: "daily weights notify NP (nurse practitioner)/MD (medical doctor) of 2 LB (pound) weight gain in 24 hr (hours)." This order was initiated on 5/21/19.

Review of Resident #47's May 2019 MAR (medication administration) record revealed that Resident #47 had a 6.4 weight gain on 5/30/19. Her weight on 5/29/19 was documented as 142.6. Her weight on 5/30/19 was documented as 149.0.

Review of the May 2019 nursing notes failed to show evidence that the physician was made aware of this weight gain on 5/30/19 per physician's order.

There was no evidence in the clinical record that the physician was made aware of this weight gain on 5/30/19. There was no negative outcome with Resident #47's weight gain on 5/30/19.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the unit manager. When asked why a resident would be on daily weights, LPN #2 stated that a resident would be on daily weights if they had a diagnosis of CHF (congestive heart failure). When asked the point of obtaining daily weights, LPN #2 stated that daily weights were obtained to see if the resident was retaining fluid. LPN #2 stated that most orders were to monitor for weight gain of 2 pounds in a 24 hour period. When asked if the MD /NP would be notified of any weight gain, LPN #2 stated that they should in case the resident is having an exacerbation of their condition. LPN # 2 stated that MD/NP notification should be documented in a nursing note. LPN #2 stated that if notification was not documented than it was not done. LPN #2 could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 56	F 658		

not find where the MD or NP were notified regarding Resident #47's weight gain. LPN #2 stated that the NP will normally give orders for a couple of doses of diuretics (fluid pills) or a reweigh for Resident #47 when she retains fluid.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

On 6/10/19 at 5:43 p.m., ASM #2 stated that the facility uses Lippincott and facility policies as professional standards/references for guiding nursing care. ASM #2 could not provide a professional reference from Lippincott regarding the above concern.

Facility policy titled, "Weight Monitoring and Tracking" did not address weight gain for a resident with CHF.

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

3b. For Resident #47, facility staff failed to accurately assess blisters to her right foot and implement a physician ordered treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 57	F 658		

Review of Resident #47's clinical record revealed that she had been hospitalized for acute hypoxic respiratory failure and arrived back to the facility on 5/14/19. The admission nursing note dated 5/14/19 documented in part, the following: Skin clear of open areas and intact."

Review of Resident #47's clinical record revealed an initial skin and wound evaluation assessment for blisters to her right medial and dorsum foot (top of foot). The following was documented on the skin assessment for her right medial foot:

"5/17/19
Type: Blister
Location: Right Medial Foot
Present on Admission
1. Area: 14.9 cm2 (centimeters squared) Length: 6.5 cm Width: 3.5 cm Depth: Not Applicable. Exudate: none...Edema: Pitting edema extends > (greater) than 4 cm (centimeters) around wound. Primary Dressing: None. Additional Care: None. (Name of NP (nurse practitioner)) notified."

The following was documented on the skin assessment for her dorsum foot:

5/17/19
Type: Blister
Location: Dorsum Right Foot
Present on Admission
1. Area 5.0 cm2 Length: 3.4 cm x Width: 2.1 cm Depth: Not Applicable. Exudate: none...Edema: Pitting edema extends > (greater) than 4 cm (centimeters) around wound. Goals of Care: Monitor/Manage: wound healing not achievable due to underlying condition.
Treatment: none. Additional Care: None. (Name

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 58	F 658		

of NP (nurse practitioner)) notified."

Further review of the weekly skin assessments revealed an assessment dated 5/22/19. This assessment documented Resident #47's blisters as "resolved" on 5/22/19.

Review of a note from the Nurse Practitioner (NP) dated 5/23/19 documented the following: "Patient seen today status post hospitalization and for follow-up weight gain /CHF (congestive heart failure), open areas to right foot...This is a 77 year old female who was admitted to the hospital secondary to altered mental status with confusion. According to the patient's daughter who was present at bedside it appeared that the patient was noted to be hypoxic (not receiving enough oxygen) with elevated blood pressures...On further questioning patient has also been noted to have worsening lower extremity edema (swelling)... Hospitalization was further complicated by development of acute diastolic CHF exacerbation requiring IV (intravenous) Lasix (1) with improvement of her symptoms. Due to her lower extremity edema she underwent PVL (Peripheral Vascular Laboratory) (2) which were positive for acute right lower extremity DVT (deep venous thrombosis) (3) for which she was started on Eliquis (4)...5/23/19. Patient seen today for follow-up post hospitalization for open area right...She has blisters to her right dorsal foot per staff. Skin was applied in last 24 hours. This a.m. noted open ulcers with pink wound bed. No drainage noted. She has moderate edema to both her extremities. I have given orders for Xeroform (5) and dry dressing to the daily staff should ACE (6) wrap both extremities daily. I have educated patient not to wear footwear until wounds are resolved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 59	F 658		

Review of Resident #47's June 2019 POS (physician order summary) revealed a current physician's order initiated on 5/23/19. The following order was documented: "Clean right foot ulcers with NS (normal saline), pat dry, apply Xerofoam (sic) and civer (sic) with dry dressing and kerlix (dry bandage roll) daily and prn (as needed) if soiled. DO not wear shoes, only grip socks until ulcer heals."

Review of Resident #47's June and May 2019 MARS (medication administration record) and TARS (treatment administration record) failed to evidence that this order was implemented.

On 6/6/19 at 11:29 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #47's nurse. When asked the process if a new skin area is found on a resident such a wound, LPN #6 stated that she will do an assessment and measure and stage the wound. LPN #6 stated that they have an electronic device that helps with measuring and staging. LPN #6 stated that they would then notify the medical doctor and obtain orders for treatment. LPN #6 stated that those orders get put into the computer system and then will show up on the MARS and/or TARS to alert nursing staff to complete those treatments. When asked how often wounds are assessed, LPN #6 stated that nurses look at the wounds every day during the dressing change but that the staff do weekly measurements on wounds. LPN #6 then added that staff even do this process for blisters. LPN #6 stated that skin/wound assessments are documented under the assessment tab in PointClickCare (electronic record). When asked if Resident #47 had any pressure areas to her feet; LPN #6 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 60	F 658		

she had blisters but that the blisters were from her fluid overload and edema, not pressure. LPN #6 stated that they were not classifying her blisters as pressure. When asked if she still had blisters to her right foot, LPN #6 stated, "They are resolved." When asked when the blisters resolved, LPN #6 looked at the 5/22/19 skin assessment and stated, "I think 5/22." When asked why the nurse practitioner would then write an order on 5/23/19 for a treatment to the blisters, LPN #6 stated, "No, it must have been found on 5/22/19 and then it opened and we got an order and it was resolved on 5/24." When asked where she was getting that the blisters had resolved on 5/24/19 if there was a current order for treatments to be done, LPN #6 stated that the order should have been discontinued. LPN #6 then stated, "Let me look into this. This doesn't make sense." LPN #6 and LPN #2, the unit manager were then asked to show this writer a timeline of when the blisters were found, when they had opened and when the blister had officially been resolved. At this time LPN #6 had discontinued the current Xeroform order.

On 6/6/19 at 3:00 p.m., an interview was conducted with LPN #2, the unit manager. LPN #2 stated that on 5/17/19 both blisters were found to the right medial and dorsum foot. LPN #2 stated that the staff were to monitor the areas and no treatments orders were given. LPN #2 stated that on 5/22, the fluid seeped out of the blisters leaving leathery skin behind but at this point the blisters were not opened. LPN #2 stated that this is when staff documented the blisters as healed. LPN #2 stated the the nurse practitioner had seen Resident #47 on 5/23/19 and had noticed the two blisters turned into one big open area. LPN #2 stated that this is when the NP wrote orders for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 61	F 658		

the Xeroform treatment. When asked if nursing documented an assessment of the open area including measurements etc., LPN #2 stated that she couldn't find an assessment. LPN #2 could not determine when the open area officially healed. An assessment could not be found in the clinical record. LPN #2 also clarified that the blisters were not classified as pressure areas due to the resident's pitting edema and DVT in her right lower leg. When asked if staff were completing the ordered Xerofoam treatments to her right foot, LPN #2 stated, "Probably not because it was never on the MAR or TAR."

On 6/6/19 at 4:15 p.m., observation was conducted of Resident #47's foot. The blisters to her right foot were healed. When asked if staff had ever applied a dressing to her right foot blisters, Resident #47 stated that staff had only ever applied her bilateral leg wraps.

On 6/7/19 at 10:30 a.m., an interview was conducted with the nurse practitioner OSM (Other staff member) #5. OSM #5 stated that Resident #47's blisters were healed because the staff were applying the Xeroform dressing. OSM #5 stated that it had healed quickly since she had ordered the dressing on 5/23. When asked if she was made aware that the staff had never applied this dressing, OSM #5 stated that she was not aware. When asked when the blisters had healed, OSM #5 stated she thought staff told her Thursday 6/6 (during survey). When asked the cause of Resident #46's blisters, OSM #5 stated that her blisters were caused by her severe edema.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 62	F 658		

#1, the clinical nurse consultant were made aware of the above concerns.

Facility policy titled, "Wound Care," documents in part, the following: "A licensed nurse will provide wound care/dressing change(s) as ordered by the physician....Document findings on Ulcer Record, until healed."

(1) Lasix used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587.
(2) PVL "is an ultrasound that looks at blood flow in the major arteries and veins in the limbs. This is used to detect PVD (peripheral vascular disease) or disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood." This information was obtained from The National Institutes of Health. https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease.
(3) DVT-" is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh." This information was obtained from The National Institutes of Health. https://medlineplus.gov/deepveinthrombosis.html.
(4) Eliquis-is indicated for the treatment of DVT (blood clot). This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e9481622-7cc6-418a-acb6-c5450daae9b0.
(5) Xeroform- Petrolatum dressing used to cover and protect low to non-exudating wounds. This information was obtained from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 63 https://www.performancehealth.com/xeroform-5x9. (6) ACE wrap- compression bandage used to reduce swelling and provide support. This information was obtained from https://www.acebrand.com/3M/en_US/ace-brand/.	F 658		
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 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: Based on observations, resident interview, staff interviews, medical record review, and facility documentation review the facility staff failed to ensure that activities of daily living necessary to maintain personal grooming was provided for 1 of 63 residents in the survey sample, Resident #48. The facility staff failed to ensure that fingernail and facial hair care was provided to Resident #48 who was unable to carry out these activity of daily grooming tasks independently. The findings included: Resident #48 was a 73 year old admitted to the facility on 10/9/17 with diagnoses to include but not limited to, generalized muscle weakness, legal blindness and dementia. The most recent comprehensive Minimum Data Set (MDS) assessment is a Significant Change with an Assessment Reference Date (ARD) of	F 677	F677 1. Fingernail and facial hair care has been provided to resident #48. 2. Residents were observed to ensure that needed fingernail and facial hair care were provided. 3. Nursing staff will be educated on: " Provision of fingernail and facial hair care 4. Nursing Administration will complete random weekly observations to ensure that fingernail and facial hair care are provided as needed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 677	Continued From page 64	F 677		

3/18/19. Resident #48's Brief Interview for Mental Status (BIMS) was a a 6 out of a possible 15 indicating the resident was cognitively impaired but capable of some daily decision making. Under Section B Hearing, Speech, and Vision Resident #48 was coded as (3) Highly Impaired in reference to "Ability to see in adequate light". Under Section G Functional Status Resident #48 was coded a 4/2 indicating the resident was totally dependent requiring one person physical assist Personal Hygiene.

Resident #48's Comprehensive Care Plan was reviewed and is documented in part, as follows:
Focus:
The resident has an ADL (Activities of Daily Living) self-care performance deficit related to deconditioning. ADL decline related to diagnosis of muscle weakness, adult failure to thrive and dementia.
Created on: 10/10/2017
Revision on: 09/20/2018

Interventions:
AM ROUTINE: assist/provide ADL care as needed
Created on: 10/10/2017
Revision on: 10/10/2017

On 06/05/19 at 11:36 AM Resident #48 was observed sitting up in his wheelchair. Resident #48's fingernails on both hands were noted to be over 1/2 inch long with dark debris noted under them. The resident was asked if he thought his fingernails were too long and if he thought they would should be shorter and if would he like them cut. Resident #48 stated, "Yes they are long and need to be cut." Resident #48 was also observed to have a least a 2 day beard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 677	Continued From page 65	F 677		

On 06/06/19 at 11:26 AM Resident #48 was observed in bed. The Resident's fingernails were still long with dark debris remaining under the nails. The Resident's facial hair still remained unshaven.

On 06/07/19 at 10:37 AM Resident #48 was observed up in his wheelchair in the dining room watching television. Resident #48 remained unshaven and fingernails remained long with debris noted under them. The Director of Nursing was asked to observe Resident #48 with surveyor and asked if she noticed anything about the resident. The Director of Nursing stated, "Well he needs to be shaved and his nails need to be trimmed." Resident #48's left hand was opened and 2 indentations were noted in his hand from his long nails being embedded in his hand. The Director of Nursing was asked what are her expectations for activities of daily living for the facilities dependent residents. The Director of Nursing stated, "I expected for the resident to be shaved and nails to be trimmed, his will be done right now." The Director of Nursing asked resident #48 if he wanted to grow a beard, Resident #48 stated, "No."

On 6/7/19 at 5:00 P.M. Resident #48 was observed up in his wheelchair and noted to have clipped clean fingernails and was clean shaven.

On 6/7/19 at 12:24 P.M. an interview was conducted with the Assistant Director of Nursing. The Assistant Director of Nursing was asked when should dependent residents have nail care and be shaven. The Assistant Director of Nursing stated, "The residents should be shaved as needed with ADL care, at least every other day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 677	Continued From page 66 The CNA's (Certified Nursing Assistants) should look at the resident's nails daily during daily care and provide nail care as needed. Nails should be kept just above the skin tip of the finger." The facility policy titled "Ancillary Nursing Care and Services" effective 2/1/15 was reviewed and is documented in part, as follows: POLICY: Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and as evidenced by hiring individuals who graduate from and approved nursing school and/or nurse aide curriculum and have successfully passed a licensing and/or certification examination. PROCEDURE: Nursing staff may utilize Mosby's Textbook for Long-Term Care Assistants, current edition, or an approved fundamental skills and concept textbook as directed by the Vice President of Clinical Services, as a reference for nursing services not otherwise provided in the MFA (Medical Facilities of America) Nursing Policies and Procedures Manual. On 6/10/19 at 8:23 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Nurse Consultant the above information was shared. Prior to exit no further information was provided.	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	F 684		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 67 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 staff interviews and clinical record review the facility staff failed to ensure 1 resident (Resident #122) of 63 residents in the survey sample received care in accordance with professional standards of practice. The facility staff failed to obtain an order for a stabilization/fracture boot which resulted in cellulitis to a surgical incision wound; and the facility staff inaccurately assessed and documented the cellulitis as a Stage 3 pressure ulcer. The findings included: Resident #122 was admitted on 04/05/2019. Diagnoses included but were not limited to, right tibial and fibular (lower leg) fracture and muscle weakness. Resident #122's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/03/2019 coded Resident #122 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #122 as requiring limited assistance of 1 for bed mobility, toilet use and personal hygiene, extensive assistance of 1 for transfer and dressing, physical help of 1 in part of bathing activity and independent with set up help only for eating.	F 684	F684 1. The fracture boot for resident #122 was discontinued on June 20, 2019. The cellulitis for Resident #122 resolved on June 19, 2019. 2. Residents with stabilization/fracture boots were reviewed to ensure that an order for use is present. Residents receiving antibiotics for treatment of cellulitis were reviewed to ensure accurate assessment of the area. 3. Charge Nurses will be educated on: " Obtaining order for stabilization/fracture boot or non-removable devices when used " Monitoring skin beneath stabilization/fracture boot or non-removable device " Assessment and documentation of incision site to include the wound and surrounding tissue " Signs and symptoms of cellulitis 4. Nursing Administration will complete a random weekly review of residents with orders for stabilization/fracture boots, non-removable devices, and surgical wounds to ensure that an order is present for the boot or device and that cellulitis is correctly identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 68 On 06/05/2019 at approximately 12:00 p.m., review of Resident #122's Skin and Wound Evaluation dated 05/01/2019 revealed that the resident was identified as having a new Pressure Ulcer-Medical Device Related Pressure Ulcer. The Pressure Ulcer was staged at a Stage 3 with 100% slough. Guidance from www.npuap.org The National Pressure Ulcer Advisory Panel (NPUAP) includes: Stage 3 Pressure Injury (ulcer): Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury Physician Orders dated 04/05/2019 revealed treatment order for: "Xeroform Petrolat Patch 4 x 4 Pad (Bismuth Tribromoph-Petrolatum) Apply to right foot surgical area topically every evening shift for surgical incision. Cleanse area with NACL (Sodium Chloride) apply Xeroform and dry dressing." Review of the Nurse Practitioner Progress Note dated 04/30/2019 revealed a note under the "History of Present Illness" with a date of 04/17/2019, it was documented in part, as follows: "Nursing also states that he is having some redness to his incision area. This writer	F 684	5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 69	F 684		

observed his incision where it is very slightly erythematous but with out any signs and symptoms of infection."

Review of the Nurse Practitioner Progress note dated 05/01/2019 revealed the following documented in part, as follows: "92 year old white male who is a skilled resident of the facility for right tibial and fibular fracture was reporting pain to therapist for approximately 2 days. Therapist uncover his boot to find out patient had increased erythema to right lower extremity linear open wounds directly from stabilization boot. Patient stabilization boot will be discontinuing, Ortho will be contacted. Patient reports increased pain. Again he is noted with erythema and sloughing to the area where he will be started on Santyl and Keflex."

Skin and Wound Evaluation for Resident #122 dated 05/01/2019 revealed information identifying a new Pressure Ulcer-Medical Device Related Pressure Ulcer, Stage 3: Full-thickness skin loss located on the Right Shin with 100% slough in wound bed.. It was documented that the Pressure Ulcer was acquired in - house. The question on the form asked, "How long has the wound been present?" It was answered, "New." Wound Measurements were documented as follows: Area: 4.2 cm2., Length: 3.1 cm., Width: 1.9 cm. Wound Pain was documented in part, as follows, "Pain Frequency: Intermittent."

Medication Administration Record for May 2019 had an order dated 05/01/2019 and is documented in part, as follows: "Hold camboot usage and call ortho to make them aware and if they want to order something else for stability of right ankle fracture one time only for open skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 70	F 684		

wound / right ankle fracture for 1 day."

Treatment Administration Record revealed that Xeroform Petrolat Patch had a D/C (Discontinue) date of 05/01/2019.

Treatment Administration Record revealed an order dated 05/02/2019 and is documented in part, as follows: "Santyl Ointment 250 Unit/GM (Collagenase) Apply to Right shin topically every evening for wound healing. Clean right shin wound with NS. Apply Santyl and dressing daily. D/C Date 05/07/2019."

Review of Nurse Practitioner Progress Note dated 05/07/2019 revealed the following, and is documented in part, as follows, "Orthopedic office states that it is okay to keep the boot off at this time. In reassessment of patient's wounds, erythema has lessened and his wounds are not draining but scabbed over. At this time Santyl will be discontinued. Patient did complete Keflex on today. Patient will start Bacitracin to linear leg wound."

Treatment Administration Record revealed an order dated 05/07/2019 and is documented in part, as follows, "Bacitracin Zinc Ointment 500 Unit/GM Apply to right leg topically every evening shift for leg wound for 10 days clean with DWC (Dakins Wound Cleanser) and apply Bacitracin to right leg wound, kerlix and the ace wrap." Last date treatment documented on kardex dated 05/17/2019."

Skin and Wound Evaluation dated 05/08/2019 revealed Pressure Ulcer, Stage 3 on Right Shin had improved. It is documented, "Wound Bed - Epithelial - 100% of wound covered, surface

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 71	F 684		

intact." Wound Measurements: Area: 1.0 cm2., Length: 1.8 cm., Width: 0.8 cm.

Skin and Wound Evaluation dated 05/14/2019 revealed Pressure Ulcer, Stage 3 on Right Shin had improved. It is documented, "Wound Bed - Epithelial - 100% of wound covered, surface intact." Wound Measurements: Area: 0.5 cm2., Length: 1.2 cm., Width: 0.6 cm.

Review of Care Plan focus created on 05/17/2019 revealed and is documented in part, as follows: "The resident has pressure ulcer (R Shin) R/T (Related To) use of fracture boot."

Review of Nurse Progress Note dated 05/21/2019 revealed and is documented in part, as follows: "Surgical and mechanical device related pressure wound to right shin healed over at time of wound assessment. Tx (Treatment) ordered discontinued."

On 06/05/2019 at approximately 12:30 p.m., the Physician Order Summary for Resident #122 for the periods of 04/05/2019 through 04/30/2019 and 05/01/2019 through 05/12/2019 was reviewed. No order for the boot was found. An order on the Physician Order Summary with an order dated of 05/13/2019 read: "Toe touch weight bearing to right leg with boot on every shift."

On 06/07/2019 at approximately 9:15 a.m., the unit nurse was asked to show Resident #122's right shin to the surveyor. The surveyor observed a dry, scabbed linear area on the right shin that was the incision site. The nurse pointed to a tan circular area next to the incision site where the pressure ulcer had been before it healed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 72	F 684		

Surveyor observed a boot with velcro straps in the residents room.

On 06/07/2019 at 9:45 a.m., an interview was conducted with Registered Nurse (RN) #2 "Unit Manager" concerning the Pressure Ulcer identified on Resident #122's right shin and she was asked, " Has Resident #122 had the same boot since admission?" RN #2 stated, "Yes." RN #2 was asked, "Could the boot be removed?" RN #2 stated, "Yes." RN #2 was asked, "When did the staff remove the boot?" RN #2 stated, " Resident #122 has a surgical incision on the right leg. The staff removed the boot daily, it was taken off for his treatment on 3-11 shift and he did not sleep in it at night." RN #2 was asked, "What can you tell me about the Stage 3 pressure ulcer on the right shin? Did he have 1 or 2 areas on the right shin?" RN #2 stated, "He had 2 areas. He had a incision site and a pressure ulcer from the boot. The boot rubbed a superficial area with slough on his leg. The Nurse Practitioner saw the wound and ordered antibiotics to include Keflex and Santyl and within a week it was healed." RN #2 was asked, "Why wasn't the wound identified before it became a Stage 3?" RN #2 stated, "The nurse may have not cleansed the wound before staging the area."

On 06/07/2019 at 11:20 a.m., an interview was conducted with the Nurse Practitioner and she was asked, "What can you tell me about the wound on Resident #122's right shin?" The Nurse Practitioner stated, "Next to the incision line the skin was red, warm to touch. The incision line had scabbed and in the breaks of the incision line it was draining yellow slough. I ordered Santyl and Keflex, monitored a couple times, asked therapy about the boot not being worn for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 73	F 684		

bit because they thought the wound was from the boot. I diagnosed it as Cellulitis."

On 06/07/2019 at approximately 3:00 p.m., the Surveyor asked the Director of Nursing (DON), "Does Resident #122 have an order for the stabilization/fracture boot?" The DON stated, "I will check."

On 06/10/2019 at approximately 10:00 a.m., the DON stated, "Here's a copy of the last page of the discharge summary from Resident #122's discharge from the hospital on 04/05/2019. Orders for the boot were on the last page and I didn't receive it until this morning." Review of the information provided revealed as documented in part, as follows: "Discharge Instructions-Non Weight bearing Right lower extremity; Daily dry dressing change as needed to R (Right) lower extremity; Fixed ankle walker to R leg to protect healing fracture. OK to remove for bathing / hygiene..."

On 06/10/2019 at 11:00 a.m., an interview was conducted with the DON and she was asked, "Was the resident admitted with the boot?" The DON stated, "Yes." The DON was asked, "Do you expect the staff to have an order for the boot?" The DON stated, "Yes." The DON was asked, "When should the staff have notified the doctor concerning the resident having the boot and no order?" The DON stated, "They should have called the doctor by the next day for an order." The DON was asked, "Did the nurse call the doctor for an order?" The DON stated, "No." The DON was asked, "Should the boot have been care planned?" The DON stated, "Yes." The DON was asked, "Was the boot care planned?" The DON stated, "No." The DON was asked,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 684	Continued From page 74 "What is the purpose of a care plan?" The DON stated, "To define the care of the resident." During the interview conducted with the Director of Nursing (DON) and the Nurse Consultant. The DON was asked, "What caused the wound next to the incision line?" The DON stated, "Thinking it was Cellulitis, coming from infection. I don't think the nurse assessed it correctly." The DON was asked. "Are your nurses trained to assess?" The DON stated, "Yes." The DON was asked, "Do your nurses know how to assess wounds?" The DON stated, "Yes." The Surveyor stated, "The wound was assessed at a Stage 3 when it was identified." The DON was asked, "Who assessed the wound?" The DON stated, "The nurse." The DON was asked, "At what stage would you expect the nurses to identify a wound?" The DON stated, " At a Stage 1." The DON was asked, "Do you think the boot caused the wound?" The DON stated, "Not sure, some of the staff thought so, not sure. Staff documented that the boot caused the wound." On 06/10/2019 at approximately 8:30 p.m., at the pre-exit meeting the Administrator, Director of Nursing and Nurse Consultant were informed of the findings. The facility did not present any further information about the findings.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 75 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to ensure 2 residents (Residents #99 & Resident #122) of 63 residents in the survey sample received care, consistent with professional standards of practice, to identify a pressure ulcer prior to an advanced stage constituting harm for Resident #99; and inaccurately assessed and documented a pressure ulcer to the shin for Resident #122. 1. The facility staff failed to identify Resident #99's left heel pressure ulcer prior to it being found at an advanced stage resulting in harm. The pressure ulcer was first identified found as an unstageable with 100% eschar (hard black dead tissue). 2. For Resident #122, the facility staff failed to accurately assess and document an area of cellulitis at a surgical incision wound on the right shin. The facility staff inaccurately assessed and documented the area as a stage 3 pressure ulcer. The findings included: 1. Resident #99 was admitted to the facility on 12/31/17. Diagnosis for Resident #99 included	F 686	F686 1. Resident #99□s left heel pressure ulcer is resolving. Resident #122□s cellulitis resolved on June 19, 2019. 2. Residents were observed for any unidentified pressure ulcer, cellulitis, or areas to the skin. 3. Charge Nurses will be educated on: " Identification of pressure ulcers, skin breakdown " Identification of cellulitis " Accurate documentation of skin assessment CNAs will be educated on: " Early identification of pressure ulcers, skin breakdown " Communication of newly identified skin breakdown 4. Nursing Administration will complete a random weekly review of resident□s skin to ensure that newly identified areas are accurately identified and assessed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 76 but not limited to *Type II Diabetes and *Congestive Heart Failure Resident #99's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 04/24/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #99 total dependent of one with toilet use, dressing, personal hygiene and transfer, extensive assistance of two with bed mobility and extensive assistance of one with bathing. Under section "M" Under section (M0150) at risk for developing pressure ulcers was coded yes. Under section (M1200) for skin and treatments was coded for having pressure reducing device for bed. Resident #99's person-centered comprehensive care plan revised on 06/06/19 documented Resident #99 with pressure ulcer and at risk for further skin impairment due to decreased mobility and incontinence. The goal: will have not further skin impairment through the next review. Some of the intervention/approaches to manage the goal included to provide *keep skin clean and dry, moisture barrier cream as needed for protection of skin, pressure reduction mattress and pressure reduction surface to wheelchair. A Braden Risk Assessment Report was completed on 03/29/19; resident scored a 16 indicating at risk for the development of pressure ulcers. Mobility is very limited; makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 77	F 686		

Review of Resident #99's Medication Administration Record (MAR) for June 2019 included the following order written on 05/31/19: *Santyl ointment-apply to left heel topically every night shift for wound healing. Cleanse with dermal wound cleanser, apply Santyl, cover with dry dressing.

On 06/05/19 at approximately 10:35 a.m., a wound care observation was conducted with License Practical Nurse (LPN) #13. Resident #99 was lying in bed, positioned in a supine position (on her back). Prior to starting wound care, LPN #13 washed her hands and donned a pair of gloves. The LPN removed the old dressing from the left heel wound, removed her gloves, used hand sanitizer, and then applied a new pair of gloves. The left heel wound dressing observed with small amount of yellow drainage with no odor. The left heel wound bed observed with yellow slough; no odor present. The wound was cleansed with wound cleanser in a circular motion x 2; gloves removed, hand sanitizer applied, a new pair of gloves applied, Santyl ointment applied to wound bed with a q-tip, covered with 2 x 2 gauze, covered with coversite, gloves removed, hands washed x 32 seconds.

Weekly skin and wound-Total Body Skin Assessment was completed on on 05/30/19 by LPN #12. Under the section for number of new wounds was coded for no new wounds.

Review of Resident #99's the clinical record written by LPN #5 revealed the following:
- 05/31/19....Resident seen by the Podiatrist with LPN #5; Deep Tissue Injury (DTI), to left heel, cleanse with DWC, apply Santyl, cover with dry dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 78	F 686		

-Clinical note dated 6/3/19 included the following: Left heel wound originally found by podiatry and charge nurse on 05/31/19. Left heel originally a DTI but debrided that day on 05/31/19. Orders received on 05/31/19 for Santyl treatment. Wound assessed by unit manager. Wound bed with minimal slough, and predominant granulated tissue, EP and moist. Wound measurement at time of assessment 3.0 cm x 2.0 cm x 0.1 cm, with moderate drainage noted. The clinical note was written by the RN-Clinical Manager on Unit 3.

An interview was conducted with the RN-Clinical Manager on Unit 3 on 06/10/19 at approximately 2:09 p.m., who stated, "I did not see Resident #99's pressure ulcer to his heel on 05/31/19. The area was found by the podiatrist and LPN #5; you will need to speak with LPN #5 for further details. She stated, "I only documented what was told to me by LPN #5."

The review of progress note written by the podiatrist on 05/31/19 at 1:06 p.m., revealed the following information:
-Black eschar has formed to the left heel (3 cm x 3 cm (centimeter) and necrotic).
-Plan: Debride ulcer to left heel with number 10 blade, apply santyl-treated with santyl and dry dressing applied.

Skin & Wound Evaluation completed on 06/05/19 included the following:
-Type (Pressure)
-Stage (Unstageable: Obsured (sic) full-thickness skin and tissue loss).
-Due to (Slough and/or eschar)
-Location (Left Heel)
-Acquired (In-House Acquired)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 79	F 686		

-How long has the wound been present (05/31/19)
-Wound Measurements (0.9 cm x 0.8 cm)
-Wound bed (Slough)
-% Slough (90% of wound filled)

An interview was conducted with LPN #5 on 06/10/19 at approximately 2:42 p.m., who assisted the podiatrist with Resident #99 on 05/31/19. The LPN stated, "I was holding Resident #99's foot for the podiatrist when I felt something hard to his left heel." She said the podiatrist looked at the area to his heel. The surveyor asked, "When did you first realize that Resident #99 had an unstageable wound to his left heel" she replied, "I did not know Resident #99 had an area to his left heel until I found it on that day (05-31-19) while assisting the podiatrist."

A phone interview was conducted with the *podiatrist on 06/07/19 at approximately at 3:45 p.m. The surveyor asked, "On 05/31/19, an area was noted on Resident #99's left heel; can you tell me what you observed?" The podiatrist said he was doing a follow up assessment on Resident #99 current wounds (arterial) to his left foot with LPN #5 assisting. He said the nurse was holding the resident's left foot in her hand when she asked me to look because she felt something hard on his heel. The podiatry stated, "I observed a hard black pressure ulcer to the heel." The surveyor asked, "What stage was the pressure ulcer" he replied, "The pressure ulcer was an unstageable wound because it was covered with hard black eschar that required debridement." He stated, "The wound was debrided, the hard covering was removed with a scalpel blade and after the debridement was done, there was still some eschar present." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 80	F 686		

podiatrist said he started Santyl ointment to continue with the chemical treatment of the left heel wound.

A phone interview was conducted with LPN #12 on 06/10/19 at approximately 5:10 p.m.. The LPN completed the weekly skin and wound assessment on 05/30/19 that read no new wounds. The LPN stated, "I did the resident's skin assessment that day and I did not notice any new areas. The surveyor asked, "How long does it take for eschar to develop" she replied, "It takes a while but it was not there on 05/30/19; that's all I can tell you."

An interview was conducted with the Director of Nursing (DON) and Cooperate Nurse on 06/10/19 at approximately 5:35 p.m. The surveyor asked, "At what stage do you expect for your nurses to first identify a pressure ulcer" she replied, "When the skin is red and blanchable but at least by a stage I."

A pre-exit meeting was held with the Administrator, Director of Nursing and Cooperate Nurse on 06/10/19 at approximately 8:25 p.m. The facility did not present any further information about the findings at the time of exit.

A pressure ulcer prevention policy was requested from the DON and Cooperate Nurse on 06/10/19 at approximately 11:12 a.m. The Cooperate Nurse said the facility does not have a policy on pressure ulcer prevention but did provide a policy on General Wound care/Dressing Changes. The policy was reviewed but did not contain any information on preventing pressure ulcers.

Definitions:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 81	F 686		

-Podiatrist is a health professional who diagnoses and treats disorders of the feet (Mosby's Dictionary of Medicine, Nursing & Health Professions).

*Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

*Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema (mayoclinic.org).

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 82	F 686		

damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

*Pressure Injury-Deep Tissue (Persistent non-blanchable deep red, maroon or purple discoloration)
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 83	F 686		

DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

2. Resident #122 was admitted on 04/05/2019. Diagnosis included but were not limited to, right tibial and fibular fracture and Muscle Weakness. Resident #122's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/03/2019 coded Resident #122 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #122 as requiring limited assistance of 1 for bed mobility, toilet use and personal hygiene, extensive assistance of 1 for transfer and dressing, physical help of 1 in part of bathing activity and independent with set up help only for eating.

On 06/05/2019 at approximately 12:00 p.m., review of Resident #122's clinical record revealed the following:

Discharge Summary from the hospital revealed Discharge Diagnosis which included but was not limited to, Right Tibia fracture S/P (Status Post) Right Tibial ORIF (Open Reduction Internal Fixation) on 03/31.

Skin and Wound Evaluation for Resident #122 dated 04/05/2019 revealed that the resident had a Surgical Incision on the Right Shin closed with Steri-Strips, present on admission. Wound Measurements: Area: 4.9 cm2., Length: 20.8 cm., Width: 0.4 cm.

The "Braden Scale For Predicting Pressure Sore

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 84	F 686		

Risk" dated 04/05/2019 revealed a score of 15.

Physician Orders dated 04/05/2019 revealed treatment order for: "Xeroform Petrolat Patch 4 x 4 Pad (Bismuth Tribromoph - Petrolatum) Apply to right foot surgical area topically every evening shift for surgical incision.
Cleanse area with NACL (Sodium Chloride) apply Xeroform and dry dressing."

Review of the Nurse Practitioner Progress Note dated 04/30/2019 revealed a note under the "History of Present Illness" with a date of 04/17/2019, it was documented in part, as follows: "Nursing also states that he is having some redness to his incision area. This writer observed his incision where it is very slightly erythematous but with out any signs and symptoms of infection."

Review of the Nurse Practitioner Progress note dated 05/01/2019 revealed the following, it was documented in part, as follows: "92 year old white male who is a skilled resident of the facility for right tibial and fibular fracture was reporting pain to therapist for approximately 2 days. Therapist uncover his boot to find out patient had increased erythema to right lower extremity linear open wounds directly from stabilization boot. Patient stabilization boot will be discontinuing, Ortho will be contacted. Patient reports increased pain. Again he is noted with erythema and sloughing to the area where he will be started on Santyl and Keflex."

Skin and Wound Evaluation for Resident #122 dated 05/01/2019 revealed information identifying a new Pressure Ulcer-Medical Device Related Pressure Ulcer, *Stage 3: Full-thickness skin loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 85	F 686		

located on the Right Shin with 100% slough in wound bed.. It was documented that the Pressure Ulcer was acquired in - house. The question on the form asked, "How long has the wound been present?" It was answered, "New." Wound Measurements were documented as follows: Area: 4.2 cm2., Length: 3.1 cm., Width: 1.9 cm. Wound Pain was documented in part, as follows, "Pain Frequency: Intermittent."

Medication Administration Record for May 2019 had an order dated 05/01/2019 and is documented in part, as follows: "Hold camboot usage and call ortho to make them aware and if they want to order something else for stability of right ankle fracture one time only for open skin wound / right ankle fracture for 1 day."

Treatment Administration Record revealed that Xeroform Petrolat Patch had a D/C (Discontinue) date of 05/01/2019.

Treatment Administration Record revealed an order dated 05/02/2019 and is documented in part, as follows: "Santyl Ointment 250 Unit/GM (Collagenase) Apply to Right shin topically every evening for wound healing. Clean right shin wound with NS. Apply Santyl and dressing daily. D/C Date 05/07/2019."

Review of Nurse Practitioner Progress Note dated 05/07/2019 revealed the following, and is documented in part, as follows, "Orthopedic office states that it is okay to keep the boot off at this time. In reassessment of patient's wounds, erythema has lessened and his wounds are not draining but scabbed over. At this time Santyl will be discontinued. Patient did complete Keflex on today. Patient will start Bacitracin to linear leg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 86	F 686		

wound."

Treatment Administration Record revealed an order dated 05/07/2019 and is documented in part, as follows, "Bacitracin Zinc Ointment 500 Unit/GM Apply to right leg topically every evening shift for leg wound for 10 days clean with DWC (Dakins Wound Cleanser) and apply Bacitracin to right leg wound, kerlix and the ace wrap." Last date treatment documented on kardex dated 05/17/2019."

Skin and Wound Evaluation dated 05/08/2019 revealed Pressure Ulcer, Stage 3 on Right Shin had improved. It is documented, "Wound Bed - Epithelial - 100% of wound covered, surface intact." Wound Measurements: Area: 1.0 cm2., Length: 1.8 cm., Width: 0.8 cm.

Skin and Wound Evaluation dated 05/14/2019 revealed Pressure Ulcer, Stage 3 on Right Shin had improved. It is documented, "Wound Bed - Epithelial - 100% of wound covered, surface intact." Wound Measurements: Area: 0.5 cm2., Length: 1.2 cm., Width: 0.6 cm.

Review of Care Plan focus created on 05/17/2019 revealed and is documented in part, as follows: "The resident has pressure ulcer (R Shin) R/T (Related To) use of fracture boot."

Review of Nurse Progress Note dated 05/21/2019 revealed and is documented in part, as follows: "Surgical and mechanical device related pressure wound to right shin healed over at time of wound assessment. Tx (Treatment) ordered discontinued."

On 06/07/2019 at approximately 9:15 a.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 87	F 686		

unit nurse was asked to show Resident #122's right shin to the surveyor. The surveyor observed a dry, scabbed linear area on the right shin that was the incision site. The nurse pointed to a tan circular area next to the incision site where the pressure ulcer had been before it healed. The Surveyor observed a boot with velcro straps in the residents room.

On 06/07/2019 at 9:45 a.m., an interview was conducted with Registered Nurse (RN) #2 "Unit Manager" concerning the Pressure Ulcer identified on Resident #122's right shin and she was asked, " Has Resident #122 had the same boot since admission?" RN #2 stated, "Yes." RN #2 was asked, "Could the boot be removed?" RN #2 stated, "Yes." RN #2 was asked, "When did the staff remove the boot?" RN #2 stated, " Resident #122 has a surgical incision on the right leg. The staff removed the boot daily, it was taken off for his treatment on 3-11 shift and he did not sleep in it at night." RN #2 was asked, "What can you tell me about the Stage 3 pressure ulcer on the right shin? Did he have 1 or 2 areas on the right shin?" RN #2 stated, "He had 2 areas. He had a incision site and a pressure ulcer from the boot. The boot rubbed a superficial area with slough on his leg. The Nurse Practitioner saw the wound and ordered antibiotics to include Keflex and Santyl and within a week it was healed." RN #2 was asked, "Why wasn't the wound identified before it became a Stage 3?" RN #2 stated, "The nurse may have not cleansed the wound before staging the area."

On 06/07/2019 at 11:20 a.m., an interview was conducted with the Nurse Practitioner and she was asked, "What can you tell me about the wound on Resident #122's right shin?" The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 88	F 686		

Nurse Practitioner stated, "Next to the incision line the skin was red, warm to touch. The incision line had scabbed and in the breaks of the incision line it was draining yellow slough. I ordered Santyl and Keflex, monitored a couple times, asked therapy about the boot not being worn for a bit because they thought the wound was from the boot. I diagnosed it as Cellulitis."

On 06/10/2019 at 11:00 a.m., an interview was conducted with the Director of Nursing (DON) and the Nurse Consultant. The DON was asked, "What caused the wound next to the incision line?" The DON stated, "Thinking it was Cellulitis, coming from infection. I don't think the nurse assessed it correctly." The DON was asked. "Are your nurses trained to assess?" The DON stated, "Yes." The DON was asked, "Do your nurses know how to assess wounds?" The DON stated, "Yes." The Surveyor stated, "The wound was assessed at a Stage 3 when it was identified." The DON was asked, "Who assessed the wound?" The DON stated, "The nurse." The DON was asked, "At what stage would you expect the nurses to identify a wound?" The DON stated, " At a Stage 1." The DON was asked, "Do you think the boot caused the wound?" The DON stated,"Not sure, some of the staff thought so, not sure. Staff documented that the boot caused the wound."

On 06/10/2019 at approximately 8:30 p.m. at pre-exit meeting the Administrator, Director of Nursing and Nurse Consultant was informed of the findings. The facility did not present any further information about the finding.

*Guidance from www.npuap.org The National Pressure Ulcer Advisory Panel (NPUAP) includes:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 89 Stage 3 Pressure Injury (ulcer): Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 63 residents (Resident #164) in the survey sample who was unable to carry out activities of daily living, received the necessary services to maintain toenail care. The facility staff failed to ensure that podiatry	F 687	F687 1. Resident #164 discharged on June 9, 2019. 2. Residents were observed to ensure that podiatry services/nail care was provided as needed. 3. Nursing staff will be educated on:	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 90 services/nail care was provided to Resident #164. The findings included: Resident #164 was originally admitted to the facility on 11/09/18 with a readmission date of 03/05/19. Diagnoses for Resident #164 included but not limited to, Cerebral Infarction and heart failure. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 01/13/19 coded the resident on the Brief Interview for Mental Status as not able to complete the interview. Resident coded as having Short term and Long term memory problems. Indicating a moderate impairment for daily decision-making. Resident #164 was coded total dependence, two person physical assistance with personal hygiene. During the initial tour on 06/04/19 at approximately 3:51 PM an interview was conducted with Resident #164's daughter and granddaughter. The family was asked by surveyor if the resident received podiatry services. She stated that usually she will trim and paint her grandmother's toenails but didn't have the time recently. The surveyor asked the family if they could show her the Resident's feet. The daughter and granddaughter said her toenails needed to be cut and trimmed. The granddaughter removed resident's sock on her left foot only. The resident's toenails were long and thick, extending over the nailbed. Surveyor was unable to determine the color of Resident's toenails because they were painted with reddish nail polish.	F 687	" Notifying podiatry of need for services " Provision of nail care as indicated 4. Nursing Administration will complete a random weekly review of toenails to ensure that toenail care has been provided as needed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 91 On 06/06/19 at approximately 3:18 PM License Practical Nurse (LPN) #11 had assessed resident's toenails. The LPN stated, "Her toenails need to be cut." The surveyor asked, "What is your process for getting resident's toenails cut and trimmed?" She said that the Resident has weekly skin checks by the nurses and Certified Nursing Assistants (CNAs). The CNAs would report to the nurse, the nurse would assess the resident toenails and if they needed to be cut then their name would be placed on the podiatry list. This surveyor and LPN #11 confirmed that the resident has not received podiatry care since her admission. On 06/07/2019 an interview was conducted with the Administrator, Director of Nursing (DON) and Corporate Nurse Consultant at approximately 3:15 PM. The surveyor asked, "What are your expectations to ensure residents receive podiatry services when needed." The DON replied, "The nurses and the CNAs (Certified Nursing Assistants) should be assessing toenails daily while performing ADL care and if a resident requires their toenails to be cut and trimmed, they are to informed the nurse.	F 687		
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	F 689		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 689	Continued From page 92 by: Based on observations, staff interviews, and clinical record review, the facility staff failed to ensure 1 of 63 residents in the survey sample, (Resident #78) was transferred according to the comprehensive care plan to prevent potential accidents. The facility staff failed to transfer Resident #78 with a mechanical lift per the resident's plan of care. The findings included: Resident #78 was admitted to the facility on 10/15/1998. Diagnosis included but were not limited to, Cerebral Palsy and Autistic Disorder. Resident #78's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 01/14/2019 coded Resident #78 with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #78 as requiring total dependence of 2 with transfers and total dependence of 1 for bed mobility, dressing, eating, toilet use, personal hygiene, bathing and locomotion on unit. On 06/10/2019 at 2:05 p.m., the Surveyor observed Certified Nursing Assistant (CNA) #2 and CNA #3 manually lift Resident #78 under the arms, while gripping a gait belt that was around the resident's waist, and manually lift and transfer the resident from the wheelchair to the bed. Resident #78's feet were noted to be approximately a foot off of the floor during transfer. There was another CNA present in room during transfer, CNA #1. CNA #2 looked	F 689	F689 1. Resident #78 is transferred according to his comprehensive care plan to prevent potential accidents. 2. Residents were reviewed to ensure that the comprehensive care plan identifies specific needs for transfers. 3. Nursing staff will be educated on: " Following the resident□s comprehensive care plan to prevent potential accidents " Communication of changes in resident condition that would require revision of the comprehensive care plan to prevent accidents 4. Nursing Administration will complete a random weekly review of comprehensive care plans to ensure that interventions identified for prevention of accidents are followed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 689	Continued From page 93	F 689		

over to the Surveyor and stated, "This is how we have to transfer Resident #78 because he is so stiff and heavy." CNA #1 stated, "We are suppose to use the lift to transfer Resident #78 but I don't know why they have the lift ordered to use. We can't use the lift, we can't get him in the bed because the lift hits the top of the bed frame." CNA #1 was asked, "Have you reported to the nurse that you can't use the lift?" CNA #1 stated, "Yes, many times."

Review of Resident #78's comprehensive care plan revealed the following: "The resident is at risk for falls R/T (Related To) unaware of safety needs, confusion, spastic movements." One of the interventions listed in the care plan is, and is documented in part, as follows: "Vanderlift transfers with two person assist."

On 06/10/2019 at 5:25 p.m., an interview was conducted with the Director of Nursing (DON) and the Nurse Consultant and the observations were discussed. The DON was asked, "How is Resident #78 transferred in and out of bed?" The DON stated, "He is a Total Assist. Should be a mechanical lift and 2 staff for all transfers." The DON was asked, "What is the purpose of a gait belt?" The DON stated, "The gait belt helps to stabilize." The DON was asked, "Is a gait belt a lifting device?" The DON stated, "No, the resident should be able to pivot when the staff use a gait belt." The DON added, "If a resident can not stand when transferred the resident can be injured." The DON was asked, "Should the staff have used the mechanical lift to transfer the resident?" The DON stated, "Yes, they should have used the lift."

The Administrator, Director of Nursing and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 689	Continued From page 94 Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 95 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on information during a complaint investigation, clinical record review, staff interviews the facility staff failed to ensure 1 of 63 residents (Resident #174) in the survey sample maintained a normal bowel elimination pattern. The facility staff failed to ensure Resident #174 maintained a normal bowel elimination at least every 3 days. Resident #174 went 6 days without having a bowel movement. The findings included: Resident #174 was originally admitted to the facility on 12/22/11. Diagnosis for Resident #174 included but not limited to *Amotrophic lateral Sclerosis (ALS), Constipation, Neurogenic Bladder and Small Bowel Obstruction. Resident #174's Minimum Data Set (MDS) with an Assessment Reference Date of 06/09/18 coded Resident # 174 Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #174 total dependence of two with bed mobility, dressing, personal hygiene, bathing and toilet use, total dependence of one with eating for Activities of Daily Living care. Under section H (Bladder and Bowel) was coded for the use of Indwelling Foley catheter and and always incontinent of bowel. Resident #174's Comprehensive care plan	F 690	F690 1. Resident #174 discharged on September 9, 2018. 2. Residents were reviewed to ensure that bowel elimination has been addressed. 3. Charge Nurses will be educated on: " Review of Bowel Movement Alerts " Provision of interventions to promote bowel elimination as indicated " MD notification of issues concerning bowel elimination CNAs will be educated on: " Documentation of bowel movements 4. Nursing Administration will complete a random weekly review of Bowel Movement Alerts to ensure that appropriate interventions were taken. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 96	F 690		

documented resident with potential for constipation related to decreased mobility, use/side effects of medications (opiods), and decreased mobility due to ALS. The goal: resident will pass soft, formed stool through the next review period (09/14/18). Some of the intervention/approaches to manage goal included: Assess bowel sounds as needed and document results, monitor medication for side effects of constipation. Keep physician informed of any problems and record bowel movements pattern each day; describe amount, color and consistency.

Bowel/Bladder Elimination Flow sheet indicating the number of Bowel Movements (BM's). The report documented BM's on the following dates of September 2016:
-09/03/16 - Returned to the facility No Bowel Movement (BM).
-09/04/16 - No BM
-09/05/16 - No BM
-09/06/16 - No BM
-09/07/16 - No BM
-09/08/16 - No BM
-09/09/16 - No BM
-09/10/16 - Large BM at 2:03 p.m.

The Medication Administration Record (MAR) for September 2016 include Resident #174 was taking Fentanyl Patch - apply transdermally every 72 hours for pain, Ferrous Sulfate 220 mg/5 ml-give 5 ml via G-tube daily as supplement, Morphine Sulfate-give 20 ml via G-tube every 6 hours for chronic pain. These drugs are known to contribute to constipation.

The MAR for September 2016 included an as needed medication for constipation:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 97	F 690		

-Dulcolax tablet 5 mg-give 1 tablet via G-Tube every 24 hours as needed for constipation.

Review of Resident #174's clinical record did not include documentation that the Dulcolax was offered, administered or refused from 09/03/16 through 09/09/16.

An interview was conducted with the Director of Nursing on 06/07/19 at approximately 2:19 p.m. The DON stated, "If Resident #174 refused to take any medication to help aide in helping to have a bowel movement then the nurse should have documented the medication was offered or refused in the residents medical record."

An interview was conducted with the Nurse Practitioner on 06/10/19 at approximately 4:48 p.m., she stated, "Due to the resident diagnosis of ALS it is hard prevent recurrent UTI's and constipation." She said Resident #174 has had multiple hospitalization due to UTI's with sepsis and bowel obstructions. She said the hospital had documented numerous times that the resident could actually die due the multiple UTI's with sepsis. She said Resident #174's UTI's were treated each time she received abnormal lab values. The NP said Resident #174's UTI's comes on acute and sudden. She stated, "ALS comes with constipation due to her limitation of movement (quadriplegia) and medication to control her pain. The resident was on a bowel regimen but unfortunately this part of her disease process." She said when the resident is assessed and if the resident has bowel sounds, without nausea/vomiting, abnormal distention or abnormal pain, I would not order anything else because she will usually have a bowel movement within 4 to 5 days with no other intervention. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 98	F 690		

NP stated, "Resident #174 should never go more than 5 days without having a bowel movement. She said the facility should have notified me if the resident had refused to take her scheduled bowel regimen medication or her as needed medications. She said I could have intervened by speaking with the resident or by calling her brother. She said sometimes she might have a smear bowel movement. The surveyor asked, "Is a smear or small considered a bowel movement" she replied, "No, a smear is not a real bowel movement but a small is to be considered a normal BM." The surveyor asked, "Should someone from the facility had notified you or the Primary Care Physician of Resident refusing her medication to avoid constipation or have not had a bowel movement in 5 days." The NP replied, "Yes, absolutely, I need to know of the resident's refusal to take her bowel regimen medication for preventing constipation, Resident #174 should not exceed 5 days without having a bowel movement, I should have been notified."

A pre-exit meeting was held with the Administrator, Director of Nursing and Cooperate Nurse on 06/10/19 at approximately 8:25 p.m. The facility did not present any further information about the findings.

The facility's policy titled Constipation Prevention (Effective date 02/01/15).
-Policy: Patients will be monitored for regular bowel elimination as evidenced by a bowel movement every three days or as determined by individual assessment, medical condition or function status.

Definitions:
*Amyotrophic Lateral Sclerosis (ALS) is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 99 nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs... At first may notice speech problems Eventually, you lose your strength and cannot move. When muscles in your chest fail, you cannot breathe. A breathing machine can help, but most people with ALS die from respiratory failure (https://medlineplus.gov/amyotrophiclateralsclerosis.html#summary). *Constipation is described as having fewer than three bowel movements a week, having hard or lumpy stools, straining to have a bowel movement, and feeling as though you can't completely empty the stool from your rectum. Risk factors include a diet low in fiber, and older female, dehydration, and use of certain medications such as; sedatives, narcotics or certain medications to the lower blood pressure. (http://www.mayoclinic.org/diseases-conditions/constipation/basics/risk-factors/con-20032773). *Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition (https://medlineplus.gov/ency/article/000754.htm). *Small Bowel Obstruction is a blockage in the small intestine. An obstruction can cause the material inside the bowel to back up into the stomach (Mayoclinic.com). Complaint deficiency.	F 690		
F 693	Tube Feeding Mgmt/Restore Eating Skills	F 693		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 693 SS=D	Continued From page 100 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure one Resident (Resident #78) of 63 resident's in the survey sample, received appropriate treatment to prevent complications from enteral feeding. The facility staff failed to ensure safety precautions were followed to prevent potential complications from enteral feeding for Resident #78 during ADL (Activities of Daily Living) care. The findings included:	F 693	F693 1. Resident #78 is receiving ADL care with safety precautions that prevent potential complications from enteral feeding. 2. Residents receiving enteral feeding were reviewed to ensure that ADL care is provided with safety precautions which prevent potential complications. 3. Nursing staff will be educated on: " Provision of ADL care for residents with enteral feeding with safety	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 693	Continued From page 101 Resident #78 was admitted to the facility on 10/15/1998. Diagnoses included but were not limited to, Cerebral Palsy and Autistic Disorder. Resident #78's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 01/14/2019 coded Resident #78 with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #78 as requiring total dependence of 2 with transfers and total dependence of 1 for bed mobility, dressing, eating, toilet use, personal hygiene, bathing and locomotion on unit. Review of resident #78's Minimum Data Set revealed that Feeding Tube was checked under Section K0510 Nutritional Approaches. On 06/10/2019 at approximately 3:30 p.m., Certified Nursing Assistant (CNA) #7 and CNA #8 were observed providing Resident #78 incontinent care and changing his brief. Resident #78 was observed to be lying flat in his bed and receiving a continuous tube feeding via a feeding pump which was going at a rate of 60 cc/hr. (cubic centimeters per hour). On 06/10/2019 at approximately 3:40 p.m., an interview was conducted with CNA #7 and CNA #8 and they were asked, "What should you do when you need to provide care to a resident who is receiving a tube feeding, the tube feeding pump is going, and you need to put the resident's head of bed down?" The CNA's responded and said they didn't know, they thought they were suppose to put the feeding on hold. CNA #7 then stated, "No, I don't think we are suppose to mess with it. I think we are suppose to tell the nurse and they turn the machine on and off."	F 693	precautions to prevent potential complications 4. Nursing Administration will complete a random weekly observation of provision of ADL care to residents receiving enteral feeding to ensure that safety precautions are followed to prevent potential complications. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 693	Continued From page 102	F 693		

On 06/10/2019 at approximately 5:35 p.m., an interview was conducted with the Director of Nursing (DON) and discussed the surveyors observation and the risk for possible aspiration when the HOB (head of bed) is down and tube feeding is running. The DON was asked, "What do you expect the nursing staff to do when they need to provide care to a resident and the resident is receiving a tube feeding?" The DON stated, "The head of the resident's bed should be up when the tube feeding is running. If the head of the bed needs to be lowered to change a resident the CNA needs to get a nurse to turn the feeding off and then get the nurse when they are finished providing care so the nurse can restart the feeding."

Review of the Order Summary Report for Resident #78 revealed an Enteral Feeding Order dated 12/19/2018 which read as follows: "Enteral Feed Order: every shift for Nutrition Jevity 1.2 at 60 ml (milliliters) per hour continuous via PEG (Percutaneous Endoscopic Gastrostomy). May hold T/F (Tube Feeding) 1-2 hours per day for ADL's, Therapy, etc. The Order Summary Report also revealed an order dated for 10/14/2014 which read as follows:
"[Enteral] Elevate HOB (Head of Bed) 30 to 45 degrees at all times during feeding and at least 1 hour after the feeding is stopped every shift."

Review of Resident #78's Person Centered Care Plan revealed an intervention created on 02/20/2014 which read as follows: "The resident needs the HOB elevated 30-45 degrees during and thirty minutes after tube feed."

The Administrator, Director of Nursing and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 693	Continued From page 103 Nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding. Definitions: PEG (Percutaneous Endoscopic Gastrostomy) Tube - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus. Source (https://www.asge.org/home/for-patients/patient-information/understanding-peg)	F 693		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure pain management was provided to 2 of 63 residents in the survey sample (Residents #30 and #47) consistent with professional standards of practice, and the comprehensive person-centered care plan. 1a. For Resident #30, facility staff failed to document the location of pain; and attempt	F 697	F697 1. Resident #30 is being assessed for pain and receiving appropriate pain management. Resident #47 is assessed for pain prior to administration of as needed medications. Resident #47 receives as needed pain medication after non-pharmacological interventions are attempted and found to be ineffective. 2. Residents receiving as needed pain	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 104 non-pharmacological pain interventions prior to the administration of PRN (as needed) pain medication on several occasions in May and June 2019. 1b. For Resident #30, facility staff failed to clarify two different orders for as needed (PRN) pain medications. 2. For Resident #47, facility staff failed to document the location of pain; and failed to attempt non-pharmacological pain interventions prior to the administration of PRN (as needed) pain medication on several occasions in May of 2019. The findings include: 1a. Resident #30 was admitted to the facility on 6/30/2003 and readmitted on 3/8/2019 with diagnoses that included but were not limited, to urinary tract infection, syncope and collapse, and atrial fibrillation. Resident #30's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (Assessment Reference Date) of 3/15/19. Resident #30 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #30 was coded in Section J as having pain on occasion. Review of Resident #30's June 2019 physician order summary documented the following orders for pain medication: 1) Hydrocodone-Acteminophen (1) Tablet 5-325 mg (milligrams) Give 0.5 tablet by mouth every 8 hours as needed for pain.	F 697	medications were reviewed to ensure that the pain was assessed and non-pharmacological interventions were attempted and found to be ineffective prior to administration of as needed medications. 3. Charge nurses will be educated on: " Documentation of pain assessment " Documentation of non-pharmacological interventions 4. Nursing Administration will complete a random weekly review of administration of as needed pain medication to ensure that the pain was assessed and non-pharmacological interventions were ineffective prior to administration of the as needed pain medication. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 105	F 697		

2) Acetaminophen (2) Tablet 325 mg Give 2 tablet by mouth every 4 hours as needed for pain."

Review of Resident #30's clinical record revealed that she received Tylenol on the following dates and times:

"5/3/19 at 12:05 p.m., 5/23/19 at 1:47 p.m., 5/28/19 at 8:45 a.m. and 5/29/19 at 8:03 a.m."

Review of the May 2019 MAR (Medication Administration Record) and the nursing notes revealed the facility staff failed to evidence the location of pain for all four dates. There was no evidence that non-pharmacological pain relief interventions were offered or attempted prior to the administration of pain medication.

Further review of Resident #30's May and June 2019 MARs revealed that she received Hydrocodone-Acetaminophen on the following dates and times:

"5/24/19 at 9:12 a.m., 5/25/19 at 8:00 a.m. and 4:33 p.m., 5/26/19 at 11:54 a.m., 5/27/19 at 1:58 p.m., 5/28/19 at 11:45 p.m., 5/29/19 at 1:30 p.m., and 11:30 p.m., 5/30/19 at 10:04 p.m., 5/31/19 at 5:00 a.m., and 1:05 p.m., 6/1/19 at 2:04 p.m., 6/3/19 at 2:35 p.m., 6/4/19 at 5:00 a.m., 6/5/19 at 4:40 a.m., 6/6/19 at 4:05 a.m."

Only two notes could be found in the clinical record documenting the location of pain on 5/25/19 at 4:33 p.m., 5/30/19 at 10:04 p.m. and 6/6 at 4:05 a.m. There was no evidence that non-pharmacological pain relief interventions were offered or attempted prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 106	F 697		

administration of pain medication.

Review of Resident #30's comprehensive care plan for pain dated 1/29/14 and revised 3/9/19, documented in part, the following: "The resident has chronic pain r/t (related to) Fibromyalgia (3) and hx (history) of knee replacement...administer analgesia per order, Encourage to try different pain relieving methods such as i.e. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, stretch out leg, sit on the side of the bed..."

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked the process if a resident complains of pain, LPN #2 stated that nursing should first complete a pain assessment by assessing the location of pain and intensity on a scale from 1-10 (10 being the worst possible pain). LPN #2 stated that if the resident cannot give a verbal descriptor of pain she would look for non-verbal cues for pain. LPN #2 stated that she would also attempt non-pharmacological pain relief interventions prior to administering pain medication such as repositioning, standing etc. LPN #2 stated that if non-pharmacological interventions were not effective, she would then administer prn pain medication. LPN #2 stated that some residents request pain medication and non-pharmacologicals would not be attempted in that situation. When asked if non-pharmacological interventions should still be offered, LPN #2 stated that nursing should still be offering non-pharmacological interventions. When asked if the pain assessment should be documented anywhere in the clinical record, LPN #2 stated that the pain assessment and non-pharmacological interventions attempted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 107	F 697		

should be documented on the MAR or in a nursing note. When asked if it was important for location of pain to be documented, LPN #2 stated that location of pain should be documented in order to track pain complaints and any new areas of pain. LPN #2 confirmed that she could not find the location of pain for the above administration times and non-pharmacological interventions attempted.

On 6/7/19 at 12:30 p.m., an interview was conducted with Resident #30. When asked if staff offered or attempted things like repositioning, massage etc. when she complains of pain, Resident #30 stated that she usually requests pain medication and the staff will give it to her. Resident #30 stated the staff never offer her non-pharmacological pain relief interventions.

On 6/7/19 at 3:26 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

(1) Hydrocodone-Acetaminophen 5/325 (Norco)- "Indicated for the management of moderate to moderately severe pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate." This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=d08cc0ab-4cb5-4290-8d46-5d8b66e8472e.
(2) Tylenol Tablet 325 mg (Acetaminophen)- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 108	F 697		

T0008785/?report=details.
(3) Fibromyalgia- "Is a disorder that causes muscle pain and fatigue. People with fibromyalgia have "tender points" on the body. Tender points are specific places on the neck, shoulders, back, hips, arms, and legs. These points hurt when pressure is put on them." This information was obtained from The National Institutes of Health. https://medlineplus.gov/fibromyalgia.html."

1b. For Resident #30, facility staff failed to clarify two different orders for PRN (as needed) pain medications.

Review of Resident #30's June 2019 physician order summary documented the following orders for pain medication:

1) "Hydrocodone-Acteminophen Tablet 5-325 mg (milligrams) Give 0.5 tablet by mouth every 8 hours as needed for pain." This order was initiated on 5/21/19.

2) "Acetaminophen Tablet 325 mg Give 2 tablet by mouth every 4 hours as needed for pain." This order was initiated on 3/8/19.

Review of Resident #30's clinical record revealed that she received Tylenol on the following dates and times:

"5/3/19 at 12:05 p.m., 5/23/19 at 1:47 p.m., 5/28/19 at 8:45 a.m. and 5/29/19 at 8:03 a.m."

Review of Resident #30's May and June 2019 MARs revealed that she received Hydrocodone-Acetaminophen on the following dates and times:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 109	F 697		

"5/24/19 at 9:12 a.m., 5/25/19 at 8:00 a.m. and 4:33 p.m., 5/26/19 at 11:54 a.m., 5/27/19 at 1:58 p.m., 5/28/19 at 11:45 p.m., 5/29/19 at 1:30 p.m., and 11:30 p.m., 5/30/19 at 10:04 p.m., 5/31/19 at 5:00 a.m., and 1:05 p.m., 6/1/19 at 2:04 p.m., 6/3/19 at 2:35 p.m., 6/4/19 at 5:00 a.m., 6/5/19 at 4:40 a.m., 6/6/19 at 4:05 a.m."

Further review of the May and June 2019 MARS revealed that Resident #30 received Hydrocodone-Acetaminophen for a pain level of 4 (on a scale of 1-10, 10 being the worst possible pain) on 5/25/19, 5/29/19, and 5/30/19.

There was no clarification or parameters (i.e. for mild, moderate, severe pain levels) identified on when to administer the appropriate pain medication.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked what pain medication she would give if a resident had two different orders for pain medication (Tylenol or Norco), LPN #2 stated, "I would generally go for Tylenol first but some patients are aware of their medications and ask for the stronger medication. "When asked if she would administer Tylenol first if a resident's pain was at a level of 10 on a scale from 1-10, LPN #2 stated that she would administer the Norco first. When asked at what point would she administer one medication over the other, LPN #2 stated that she would administer Tylenol for mild pain or pain at a level of 1-4 and Norco at a pain level of 6 and greater. When asked if all nurses had the same perception of what constitutes mild, moderate and severe pain, LPN #2 stated yes. When asked if it was possible for a nurse to administer Norco

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 110	F 697		

for pain level of 2 or 4, LPN #2 stated that it was possible especially if the resident requests a certain pain medication. LPN #2 stated that the nurses could not argue with the resident if they wanted Norco for a pain level of 2. LPN #2 stated that the facility was so geared to pleasing the patients. When asked if the above orders should have parameters on when to give which one, LPN #2 stated that parameters probably should be in place because Resident #30 has chronic pain and will always want the stronger medication.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

2. For Resident #47, facility staff failed to document the location of pain; and failed to attempt non-pharmacological pain interventions prior to the administration of PRN (as needed) pain medication on several occasions in May of 2019.

Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded in Section J as frequently having pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 111	F 697		

Review of Resident #47's June 2019 physician order summary documented the following orders for pain medication:
"Percocet (1) Tablet 5-325 mg Give 1 tablet by mouth every 6 hours as needed for pain." This order was initiated on 5/14/19.

Review of Resident #30's May 2019 MAR (Medication Administration Record) revealed that she received Percocet on the following dates and times:

5/14/19 at 10:09 a.m., 5/16/19 at 3:50 p.m., 5/17/19 at 3:20 p.m. and 11:15 p.m., 5/18/19 at 8:17 a.m., 5/19/19 at 8:16 a.m., 5/20/19 at 7:55 a.m., 5/21/19 at 8:07 a.m., 5/22/19 at 3:34 p.m., 5/23/19 at 10:14 p.m., 5/24/19 at 8:00 a.m., and 1:50 p.m., 5/25/19 at 8:00 a.m. and 10:06 a.m., 5/28/19 at 4:25 p.m., 5/29/19 at 8:06 a.m., and 2:55 p.m., 5/30/19 at 8:23 a.m., and 5/31/19 at 8:42 a.m.

Further review of Resident #47's clinical record revealed that location of pain was documented in the nursing notes for only 7 out of the 19 administration times of PRN Percocet. Location of pain was documented on 5/16/19 at 3:50 p.m., 5/17/19 at 3:20 p.m., 5/20/19 at 7:55 a.m., 5/22/19 at 3:34 p.m., 5/23/19 at 10:14 p.m., 5/25/19 at 10:06 a.m., and 5/30/19 at 8:23 a.m.

There was no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Percocet on all above dates.

On 6/7/19 and 6/9/19 several attempts were made to interview Resident #47. She could not be reached for an interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 112	F 697		

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked the process if a resident complains of pain, LPN #2 stated that nursing should first complete a pain assessment by assessing the location of pain and intensity on a scale from 1-10 (10 being the worst possible pain). LPN #2 stated that if the resident cannot give a verbal descriptor of pain she would look for non-verbal cues for pain. LPN #2 stated that she would also attempt non-pharmacological pain relief interventions prior to administering pain medication such as repositioning, standing etc. LPN #2 stated that if non-pharmacological interventions were not effective, she would then administer prn pain medication. LPN #2 stated that some residents request pain medication and non-pharmacologicals would not be attempted in that situation. When asked if non-pharmacological interventions should still be offered, LPN #2 stated that nursing should still be offering non-pharmacological interventions. When asked if the pain assessment should be documented anywhere in the clinical record, LPN #2 stated that the pain assessment and non-pharmacological interventions attempted should be documented on the MAR or in a nursing note. When asked if it was important for location of pain to be documented, LPN #2 stated that location of pain should be documented in order to track pain complaints and any new areas of pain. LPN #2 confirmed that she could not find the location of pain for the above administration times and non-pharmacological interventions attempted.

On 6/7/19 at 3:26 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 113 (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns. (1) Percocet- (Oxycodone/Acetaminophen) opioid used to treat moderate to severe pain. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to communicate an ongoing assessment for one (Resident #421) of 63 residents in the survey sample, for monitoring of complications before after dialysis treatment. The facility staff failed to communicate an ongoing assessment with the dialysis center where Resident #421 attended outpatient dialysis three days per week every Monday, Wednesday and Friday. The findings included: Resident #421 was admitted to the facility on	F 698	F698 1. Communication of ongoing assessment with the dialysis center is being done for Resident #421. 2. Residents receiving dialysis were reviewed to ensure that documentation of communication with the dialysis center is present. 3. Charge nurses will be educated on: " Documentation of communication of ongoing assessment of the Resident between the facility and the dialysis center 4. Nursing Administration will complete a random weekly review of documentation of communication regarding ongoing	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 114 05/30/19. Diagnosis for Resident #421 included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week on Monday, Wednesday and Friday. The resident's Minimum Data Set (MDS) assessment was not due therefore no information was obtained from an MDS. The Admission Assessment completed on 05/30/19 included the following: alert to person, place, time and situation with intact cognition. The interim care plan created on 05/31/19 documented Resident #421 needs hemodialysis every Monday, Wednesday and Friday related to renal failure. The goal set for the resident included: the resident will have immediate attention should any signs/symptoms of complications from dialysis. Some of the intervention/approaches to manage goal include to monitor/document/report as needed any signs/symptoms of infection to access site; redness, swelling, warmth or drainage, lab work as ordered, do not draw blood or take blood pressure in arm with graft and check and change dressing as ordered at access site. Resident #421's physician orders contained the following orders (active as of 06/06/19): Dialysis at (local dialysis center) every Monday, Wednesday and Friday. An interview was conducted with Resident #421 on 06/05/19 at approximately 12:00 p.m. The resident stated "I do not remember anyone giving me any papers to take to dialysis." Resident #421	F 698	assessment of the resident between the facility and the dialysis center. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 115	F 698		

was admitted to the facility on 05/30/19. Resident #421's clinical record was missing dialysis communication forms for the following days: 05/31/19, 06/03/19 and 06/05/19.

An interview was conducted with RN-Clinical Manager on Unit 3 on 06/06/19 at approximately 10:42 a.m. The RN said she was unable to locate any of Resident #421's Dialysis Communication Forms in his clinical record since his admission. The RN stated, "We complete section A of the Dialysis Communication Form and the dialysis center is to complete the remaining sections of the form." She said the dialysis center does not always complete the communication form sent over by the resident. The RN said they are to call the dialysis center right away and request the dialysis communication form to be completed then faxed to the facility but it does not always happen. The surveyor asked, "What is the purpose of the Dialysis Communication Form" she replied, "To receive the resident's pre and post weight, vital signs and any issues that may have occurred while at dialysis. She said without the communication form being completed; we really don't know what occurred doing Resident #421's stay while he was at dialysis."

An interview was conducted with the Director of Nursing (DON) and Cooperate Nurse on 06/10/19 at approximately 11:05 a.m., who stated, "The nurses are to fill out the top portion of the Dialysis Communication Form then scan the form in the resident's clinical record. She said the form is sent to dialysis and given to the dialysis center. The dialysis center is to complete the communication form and return it back to the facility. The DON said if the communication form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 116	F 698		

does not return with the resident, the staff are to call the dialysis center for the completed form. Once the form is received then they staff is to scan the form into the residents clinical record.

A pre-exit meeting was held with the Administrator, Director of Nursing and Cooperate Nurse on 06/10/19 at approximately 8:25 p.m. The facility did not present any further information about the findings.

The facility's policy titled Hemodialysis Care (Effective 09/20/18).
-Policy: A license nurse will be responsible for monitoring access grafts/devices as ordered by the physician.

Procedure include but not limited to:
-7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis center's designated form may be used in pace of MFA's Dialysis Communication Form.
-8. Patient reports received from dialysis center will be uploaded to the patient's Electronic Health Record (EHR).

Definitions:
*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

*For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 117 under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301).	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 118 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on the facility's medication storage review/inspection of 4 medication carts and 2 medication rooms, the facility staff failed to dispose of Resident #471's medications after the resident was discharged, and failed to ensure accountability for controlled medications awaiting final disposition. The findings include: Resident #471 was admitted to the facility from an acute care facility with diagnoses that included but not limited to Diabetes mellitus, hyperlipidemia, and chronic pain. The resident was discharged on 05/15/19. On 06/06/19 at approximately 10:56 AM an inspection was made in the medication storage room with Licensed Practical Nurse #6 (LPN). LPN #6 was not able to get into a locked cabinet that she stated that expired narcotics or medications were put. She said that the only staff members that have a key to the cabinet is the Director Of Nurses (DON). She was asked to have the DON unlock the cabinet for inspection. On 06/06/19 at approximately 11:09 AM the unit manager LPN #2 returned with the key and unlocked the cabinet. She stated that they keep narcotics that will be destroyed. She stated that once a resident is discharged from the facility	F 755	F755 1. Resident #471 discharged from the facility on May 15, 2019. The medications were disposed in an appropriate manner. 2. Medication rooms were observed to ensure that medications were stored appropriately. 3. Charge Nurses will be educated on: " Return of non-controlled medications when resident discharges " Destruction of controlled medications when resident discharges 4. Nursing Administration will complete a random weekly observation of medication rooms to ensure appropriate storage of medications. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 119 they will keep the resident's medications for thirty days. "The medication has been here for three weeks, since resident was discharged." "I was going to call the Resident's family to pick up the medications." LPN#2 stated there is a policy to keep resident medications once they are discharged for thirty days and it's been three weeks now. Located on the top shelf was a large storage bag filled with the following medications: alprazolam 0.5 MG 1 tab po twice daily. Citalopram 20 mg, Bisoprolol Fumara HCTZ 5-6.25 MG Atorvastatin 40 MG. Synthroid 150 MCG. Pantoprazole 40 MG, Nasal Solution Azelastine HCL and Bayer Aspirin. There was no control sheet for the alprazolam or citaloprm. When the unit manager was asked for it she stated there wasn't any. When asked how would she know if some of the medicine wasn't missing by not having a control count sheet, she said she didn't know. On 06/06/19 at approximately 11:35 AM, LPN #2 stated "There is no policy." On 06/07/19 at approximately, 3:15 PM a pre-exit interview was conducted with the Nurse Consultant, the Director Of Nursing and the Administrator. The Nurse Consultant stated that there wasn't a policy available.	F 755		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 120 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility document review, it was determined that facility staff failed to ensure residents were free from unnecessary pain medications for two of 63 residents in the survey sample, Resident #30 and #47. 1. For Resident #30, facility staff failed to attempt and/or offer non-pharmacological interventions prior to the administration of pain medication on several occasions in May and June of 2019. 2. For Resident #47, facility staff failed to attempt and/or offer non-pharmacological interventions prior to the administration of pain medication on several occasions in May of 2019. The findings include:	F 757	F757 1. Resident #30 is being assessed for pain and receiving attempted non-pharmacological interventions prior to administration of as needed medications. Resident #47 receives as needed pain medication after non-pharmacological interventions are attempted and found to be ineffective. 2. Residents receiving as needed pain medications were reviewed to ensure that non-pharmacological interventions were attempted and found to be ineffective prior to administration of as needed medications. 3. Charge nurses will be educated on: " Documentation of non-pharmacological interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 121 1. Resident #30 was admitted to the facility on 6/30/2003 and readmitted on 3/8/2019 with diagnoses that included but were not limited to urinary tract infection, syncope (fainting) and collapse, and atrial fibrillation. Resident #30's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/15/19. Resident #30 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #30's June 2019 physician order summary documented the following orders for pain medication: 1) Hydrocodone-Acteminophen (1) Tablet 5-325 mg (milligrams) Give 0.5 tablet by mouth every 8 hours as needed for pain. 2) Acetaminophen (Tylenol) (2) Tablet 325 mg Give 2 tablet by mouth every 4 hours as needed for pain." Review of Resident #30's clinical record revealed that she received Tylenol on the following dates and times: "5/3/19 at 12:05 p.m., 5/23/19 at 1:47 p.m., 5/28/19 at 8:45 a.m. and 5/29/19 at 8:03 a.m." There was no evidence that non-pharmacological pain relief interventions were offered or attempted prior to the administration of pain medication. Further review of Resident #30's May and June 2019 MARs revealed that she received	F 757	4. Nursing Administration will complete a random weekly review of administration of as needed pain medication to ensure that non-pharmacological interventions were ineffective prior to administration of the as needed pain medication. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 122	F 757		

Hydrocodone-Acetaminophen on the following dates and times:

"5/24/19 at 9:12 a.m., 5/25/19 at 8:00 a.m. and 4:33 p.m., 5/26/19 at 11:54 a.m., 5/27/19 at 1:58 p.m., 5/28/19 at 11:45 p.m., 5/29/19 at 1:30 p.m., and 11:30 p.m., 5/30/19 at 10:04 p.m., 5/31/19 at 5:00 a.m., and 1:05 p.m., 6/1/19 at 2:04 p.m., 6/3/19 at 2:35 p.m., 6/4/19 at 5:00 a.m., 6/5/19 at 4:40 a.m., 6/6/19 at 4:05 a.m."

There was no evidence that non-pharmacological pain relief interventions were offered or attempted prior to the administration of pain medication.

Review of Resident #30's comprehensive care plan for pain dated 1/29/14 and revised 3/9/19, documented in part, the following: "The resident has chronic pain r/t (related to) Fibromyalgia (3) and hx (history) of knee replacement...administer analgesia per order, Encourage to try different pain relieving methods such as i.e. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, stretch out leg, sit on the side of the bed..."

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the unit manager. When asked the process if a resident complains of pain, LPN #2 stated that nursing should first complete a pain assessment by assessing the location of pain and intensity on a scale from 1-10 (10 being the worst possible pain). LPN #2 stated that if the resident cannot give a verbal descriptor of pain she would look for non-verbal cues for pain. LPN #2 stated that she would also attempt non-pharmacological pain relief interventions prior to administering pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 123	F 757		

medication such as repositioning, standing etc. LPN #2 stated that if non-pharmacological interventions were not effective, she would then administer prn pain medication. LPN #2 stated that some residents request pain medication and non-pharmacologicals would not be attempted in that situation. When asked if non-pharmacological interventions should still be offered, LPN #2 stated that nursing should still be offering non-pharmacological interventions. When asked if the pain assessment should be documented anywhere in the clinical record, LPN #2 stated that the pain assessment and non-pharmacological interventions attempted should be documented on the MAR or in a nursing note. LPN #2 confirmed that she could not find non-pharmacological interventions attempted prior to the administration of pain medications.

On 6/7/19 at 12:30 p.m., an interview was conducted with Resident #30. When asked if staff offered or attempted things like repositioning, massage et. when she complains of pain, Resident #30 stated that she usually requests pain medication and the staff will give it to her. Resident #30 stated the staff never offer her non-pharmacological pain relief interventions.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

(1) Hydrocodone-Acetaminophen 5/325 (Norco)- "Indicated for the management of moderate to moderately severe pain severe enough to require an opioid analgesic and for which alternative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 124	F 757		

treatments are inadequate." This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=d08cc0ab-4cb5-4290-8d46-5d8b66e8472e.
(2) Tylenol Tablet 325 mg (Acetaminophen)- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.
(3) Fibromyalgia- "Is a disorder that causes muscle pain and fatigue. People with fibromyalgia have "tender points" on the body. Tender points are specific places on the neck, shoulders, back, hips, arms, and legs. These points hurt when pressure is put on them." This information was obtained from The National Institutes of Health. https://medlineplus.gov/fibromyalgia.html."

2. For Resident #47, facility staff failed to attempt and/or offer non-pharmacological interventions prior to the administration of pain medication on several occasions in May of 2019.

Resident #47 was admitted to the facility on 12/14/18 and readmitted on 5/14/18 with diagnoses that included but not limited to, heart failure, chronic obstructive pulmonary disease, type two diabetes and muscle weakness. Resident #47's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #47 was coded as coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #30's June 2019 physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 125	F 757		

order summary documented the following orders for pain medication:
"Percocet (1) Tablet 5-325 mg Give 1 tablet by mouth every 6 hours as needed for pain." This order was initiated on 5/14/19.

Review of Resident #30's May 2019 MAR (Medication Administration Record) revealed that she received Percocet on the following dates and times:

5/14/19 at 10:09 a.m., 5/16/19 at 3:50 p.m., 5/17/19 at 3:20 p.m. and 11:15 p.m., 5/18/19 at 8:17 a.m., 5/19/19 at 8:16 a.m., 5/20/19 at 7:55 a.m., 5/21/19 at 8:07 a.m., 5/22/19 at 3:34 p.m., 5/23/19 at 10:14 p.m., 5/24/19 at 8:00 a.m., and 1:50 p.m., 5/25/19 at 8:00 a.m. and 10:06 a.m., 5/28/19 at 4:25 p.m., 5/29/19 at 8:06 a.m., and 2:55 p.m., 5/30/19 at 8:23 a.m., and 5/31/19 at 8:42 a.m.

There was no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Percocet on ALL above dates.

On 6/7/19 and 6/9/19 several attempts were made to interview Resident #47. She could not be reached for an interview.

On 6/7/19 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the unit manager. When asked the process if a resident complains of pain, LPN #2 stated that nursing should first complete a pain assessment by assessing the location of pain and intensity on a scale from 1-10 (10 being the worst possible pain). LPN #2 stated that if the resident cannot give a verbal descriptor of pain she would look for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 126	F 757		

non-verbal cues for pain. LPN #2 stated that she would also attempt non-pharmacological pain relief interventions prior to administering pain medication such as repositioning, standing etc. LPN #2 stated that if non-pharmacological interventions were not effective, she would then administer prn pain medication. LPN #2 stated that some residents request pain medication and non-pharmacologicals would not be attempted in that situation. When asked if non-pharmacological interventions should still be offered, LPN #2 stated that nursing should still be offering non-pharmacological interventions. When asked if the pain assessment should be documented anywhere in the clinical record, LPN #2 stated that the pain assessment and non-pharmacological interventions attempted should be documented on the MAR or in a nursing note. LPN #2 confirmed that she could not find non-pharmacological interventions attempted prior to the administration of the above pain medications. LPN #2 then stated that Resident #47 was a resident who always had chronic pain with walking. LPN #2 stated that staff are always telling her to lay down and rest and that the staff should be taking credit for those interventions and documenting in the clinical record.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

A policy could not be provided addressing the above concerns.

(1) Percocet- (Oxycodone/Acetaminophen) opioid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 127 used to treat moderate to severe pain. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e .	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility staff failed to store and label food in a safe, sanitary manner. The findings included:	F 812	F812 1. Food is being stored correctly in the walk in freezer. 2. Food is being stored, prepared, and distributed in accordance with professional standards for food service	7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 812	Continued From page 128 On 06/04/2019 at 3:05 p.m., during the initial tour of the kitchen, the surveyor was escorted into the walk in freezer and the following observations were made: an open box of Tilapia Fillets, uncovered and not labeled; an opened, unsealed, and unlabeled bag of broccoli sitting on top of egg patties in a box; an opened box of egg patties not dated; and a second box of egg patties also observed to be opened, unsealed and not dated. The Dietary Aide stated, "That's crazy. Broccoli, egg patties and Tilapia should be covered." On 06/10/2019 at 10:20 a.m., an interview was conducted with the Dietary Manager and he was asked, "What should happen when a case of food is opened?" The Dietary Manager stated, " The box should be dated when it is opened and when it is to be used by." The Dietary Manager was asked, "Should the bag of broccoli have been closed?" The Dietary Manager stated, "Yes, bags should be closed, wrapped and dated." The Dietary Manager stated, "Error on our behalf. The frozen broccoli should have been closed. The boxes should have been closed." The Administrator, Director of Nursing and the nurse Consultant was informed of the finding on 06/10/2019 at approximately 8:30 p.m. The facility staff did not present any further information about the finding.	F 812	safety. 3. Dietary staff will be educated on: " Storage of food " Labeling with date " Closing of bags and boxes 4. The Registered Dietician will complete a random weekly review of food storage to ensure that food is stored, prepared, and distributed in accordance with professional standards for food service safety. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		7/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 129	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 130 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to follow infection control practices therefore, increasing the chance of spreading infections, illnesses and diseases for 3 of 63 residents in the survey sample (Residents #39, 113, &104) and 7 dining room residents. 1. The Facility staff failed to perform hand hygiene before assisting 7 Residents during mealtime. 2. The facility staff failed to ensure Resident #39's indwelling catheter was managed in a manner to minimize the risk of cross-contamination and infections.	F 880	F880 1. Facility staff are using proper hand hygiene during mealtime. Resident #39□s indwelling catheter is managed in a manner to minimize risk of cross-contamination and infections. Resident #113□s Foley catheter is maintained in a sanitary manner. Resident #104□s oxygen tubing is maintained in a sanitary manner. 2. Residents will receive assistance for meals by staff using hand hygiene performed in between residents. Residents with low beds and a Foley	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 131 3. For Resident #113, facility staff failed to maintain his Foley catheter in a sanitary manner. 4. For Resident #104, facility staff failed to maintain respiratory equipment in a sanitary manner. The Findings Included; 1. On 06/07/19 at approximately 1:25 PM during a dining room observation in the Dayroom on unit two, three Certified Nursing Assistants (CNAs) were observed serving, feeding and assisting seven residents during mealtime without performing hand hygiene in between residents. On 06/07/2019 at approximately 2:30 PM interviews were conducted with CNA #1 and CNA #2. They were interviewed separately in the conference room concerning the observation of not performing hand hygiene as they assisted or fed the residents in the Day Room on Unit 2. They both said that there's no dispenser or hand sanitizer available in the Day Room. On 06/07/19 at approximately 3:15 PM a Pre-exit interview was conducted with the Nurse Consultant, Director Of Nursing and the Administrator was present. The above findings were discussed. No comments were made. 2. Resident #39 was originally admitted to the facility on 04/24/18. Diagnosis includes but limited to *Neuromuscular Dysfunction of Bladder, *Urinary Tract Infection (UTI) and Gross *Hematuria.	F 880	catheter were reviewed to ensure that the catheter bag and tubing are not touching the floor and/or are enclosed in a drainage bag cover. Residents receiving oxygen were reviewed to ensure that tubing is not touching the floor. 3. Nursing staff will be educated on: " Hand hygiene in between residents during mealtime " Use of a drainage bag cover to prevent Foley bag and tubing from touching the floor " Use of appropriate length of oxygen tubing " Keeping respiratory tubing off the floor 4. Nursing Administration will complete random weekly reviews of infection control practices to prevent the spread of infections, illnesses, and diseases. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: July 24, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 132	F 880		

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 03/19/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #39 as dependent of one staff with bathing, toilet use and transfer, extensive assistance of two with bed mobility, extensive assistance of one with dressing and personal hygiene. In addition, under section H (Bladder and Bowel) was coded for the use of indwelling *Foley catheter.

*Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).

The review of Resident #39's Physician Order Sheet for June 2019 revealed the following orders: Suprapubic catheter #16/10cc (cubic centimeters) every shift related to Neuromuscular Dysfunction of Bladder, Foley care every shift and Flush Foley with 100 cc normal saline every evening shift for recurrent hematuria.

Resident #39's care plan with a revision date of 05/13/19 documented resident with indwelling, suprapubic Foley catheter related to neuromuscular dysfunction of the bladder. The goal: resident will be/remain free from catheter-related trauma. Some of the intervention/approaches to manage goal include; catheter change as ordered by the urology, position catheter bag and tubing below the level of the bladder and flush Foley catheter twice weekly as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 133	F 880		

During the initial tour on 06/04/19 at 4:38 p.m., Resident #39's was observed lying bed with bed in low position. The Foley catheter bag and tubing were observed resting on the floor mat beside his bed. The Foley catheter tubing was observed with sediment. On 06/05/19 at approximately 2:49 p.m., resident's Foley catheter bag and tubing remained unchanged; the catheter bag and tubing were on the floor mat. On 06/06/19 at approximately 10:15 a.m., Resident #39's Foley catheter bag and tubing remained on the floor mat beside the bed.

On 06/06/19 at approximately 10:15 a.m., an interview was conducted with License Practical Nurse (LPN) #8 who stated, "Resident #39's catheter bag and tubing should be attached to the bed but not position on the floor. She said this could lead to an infection control issue. The LPN raised Resident #39's bed so the Foley catheter bag and tubing would not be touching the floor/mat.

An interview was conducted with the Director of Nursing (DON) on 06/06/19 at approximately 10:24 a.m. The DON said Resident #39 has a low bed with mats. She said the nurses had been instructed to put Resident #39's Foley catheter bag inside a drainage bag cover. She said the Foley catheter bag or tubing cannot touch the floor; this is an infection control issue.

On 06/10/19 at approximately 10:45 a.m., an interview was conducted with the Staffing Development Coordinator (SDC). He said the Foley catheter bag and tubing should not touch the floor and or mat. He said this is an infection control problem.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 134	F 880		

A pre-exit meeting was held with the Administrator, Director of Nursing and Nurse Consultant on 06/10/19 at approximately 8:25 p.m. The facility did not have any further questions or present any further information about the findings.

The Center of Disease Control (CDC) - Guidelines for Prevention of Catheter-Associated Urinary Tract Infections

Proper Techniques for Urinary Catheter Maintenance
-Maintain unobstructed urine flow.
-Keep the catheter and collecting tube free from kinking.
-Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.
3. For Resident #113, facility staff failed to maintain his Foley catheter in a sanitary manner.

Resident #113 was readmitted on 2/20/19 with diagnoses that included but were not limited to, neuromuscular dysfunction of the bladder, muscle weakness, stroke with hemiplegia of the right side, and heart disease. Resident #113's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (Assessment Reference Date) of 4/29/19. Resident #113 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #113 was coded in Section H (Bladder and Bowel) as having a urinary catheter.

Review of Resident #113's June 2019 POS (physician order summary) revealed the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 135	F 880		

order: "Foley catheter 16 F (French)/5 cc every shift related to NEUROMUSCULAR DYSFUNCTION OF BLADDER."

On 6/4/19 at 3:15 and 3:51 p.m., (during tour) observations were made of Resident #113's catheter. Resident #113's bed was lowered all the way to the ground. His catheter bag was touching the ground. The catheter was not in a privacy/dignity bag, the catheter had a privacy flap that covered the catheter bag on one side.

On 6/6/19 at 5:15 p.m., an observation was made of Resident #113's catheter. Resident #113's bed was lowered all the way to the ground. His catheter bag was touching the ground. The catheter was not in a privacy/dignity bag, the catheter had a privacy flap that covered the catheter bag on one side.

On 6/6/19 at 5:18 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #6, a CNA on the unit. CNA #6 confirmed that Resident #113's catheter was touching the ground. CNA #6 stated that Resident #113 had to have his bed lowered due to him being a fall risk. CNA #6 stated that she was not sure how she would raise the bag or what she could do to prevent it from touching the floor. When asked why the catheter bag should not be touching the floor, CNA #6 stated that it was not sanitary. When asked if she was Resident #113's CNA that shift, CNA #6 stated that she will assist him at times but that his assigned CNA had put him into bed that shift. CNA #6 stated that his assigned CNA was currently busy in the dining room.

On 6/7/19 at 3:26 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 136	F 880		

(Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

Facility policy titled, "Infection Prevention and Control Practices and Procedures," did not address the above concerns.

4. For Resident #104, facility staff failed to maintain respiratory equipment in a sanitary manner.

Resident #104 was admitted to the facility on 3/5/18 and readmitted on 1/8/19 with diagnoses that included but were not limited to abdominal hernia with obstruction, muscle weakness, congestive heart failure, COPD (chronic obstructive pulmonary disease), and high blood pressure. Resident #104's most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (Assessment Reference Date) of 4/28/19. Resident #104 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #104 was coded in Section O. "Special Treatment and Programs," as receiving oxygen therapy.

On 6/4/19 at 4:27 p.m. an observation was made of Resident #104. She was lying in bed with her oxygen in use set at 3 liters via nasal cannula. Her oxygen tubing was very long and most of the tubing was lying on the ground. On 6/4/19 at 4:28 p.m. a nurse entered her room to give Resident #104 her inhaler. This nurse exited her room after administering the inhaler and did not notice the oxygen tubing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 880	Continued From page 137	F 880		

On 6/5/19 at 9:21 a.m., an observation was made of Resident #104. She was lying up in bed eating breakfast. Her oxygen was on via nasal cannula at 3 liters. Her oxygen tubing was very long and most of the tubing was lying on the ground.

On 6/7/19 at 9:10 a.m. and 10:21 a.m., an observation was made of Resident #104. She was lying in bed with her oxygen on at 3 liters via nasal cannula in place. Her oxygen tubing was very long and most of the tubing was lying on the ground.

On 6/7/19 at 9:53 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked how oxygen tubing should be kept to maintain infection control, LPN #2 stated that tubing should never be touching the floor. LPN #2 stated that all of the tubing should be kept up off the floor. When told LPN #2 about the above observations, LPN #2 stated that Resident #104 mostly stays in bed and that she could use shorter oxygen tubing. LPN #2 stated, "I'll check that."

On 6/7/19 at 3:26 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and Corporate staff member #1, the clinical nurse consultant were made aware of the above concerns.

Facility policy titled,"Respiratory/Oxygen Equipment," did not address the above concerns.