STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	C 07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 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 07/16/19 through 07/19/19. 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 07/16/19 through 07/19/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 3 complaints were investigated during the survey. The census in this 120 certified bed facility was 92 at the time of the survey. The survey sample consisted of 33 current Resident reviews and 6 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		8/26/19

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

Electronically Signed | 08/09/2019

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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 and staff interview, the facility staff failed to enhance and promote dignity during medication administration for one resident, Resident #57 in a survey sample of 39 residents. The findings included: The facility staff failed to knock upon entering Resident #57's room during medication on the Garden Spring Unit.	F 550	1. A direct observation was made by survey staff on the Garden Spring House during survey. No immediate correction is possible. Resident #57 was assessed for mood and behavior on 08/14/19 with no decline noted. Resident #57 remains oriented x 1-2 and engages with staff at times of his choice which is his baseline. 2. All residents on the Garden Spring House are at risk. 3. 100% of facility staff will be inserviced	

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F 550	Continued From page 2 Resident #57 was admitted to the facility on 10/14/17 from the community and has never been discharged. Diagnoses included, but not limited to, Vascular Dementia and Type 2 Diabetes Mellitus. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/15/19 coded the resident as having short-term and long- term memory problems. Cognitive skills for decision making coded the resident as being severely impaired never/rarely making decisions. On 07/17/19 at approximately 4:30 PM Licensed Practical Nurse (LPN) #3 entered the resident's room to administer medications on two occasions without knocking before entering. On 07/18/19 at approximately 3:44 PM an interview was conducted with Licensed Practical Nurse #5 and she was asked if it was important to knock before entering into a resident's room. She stated "Yes, this is considered their home and each room is considered their apartment." On 07/18/19 at approximately 3:58 PM an interview was conducted with Licensed Practical Nurse #3 concerning her entering the resident's room without knocking. Her response was, "I should have knocked." "It's a dignity issue." "It's their home." On 07/18/19 at approximately 4:02 PM an interview was conducted with Certified Nursing Assistant (CNA) #2, when asked if it's important to knock before entering resident's rooms she stated, "Yes, because it's a dignity and privacy	F 550	on Sentara Life Care policy entitled Resident Rights and Responsibilities specifically regarding the resident's right to be treated with dignity and respect 08/06/19-08/22/19. 4. The Clinical Manager's will audit staff behavior twice weekly x 8 weeks to assure staff are knocking on resident doors before entering rooms. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 550	Continued From page 3 issue." On 7/18/19 at approximately 4:12 PM, a pre-exit interview was conducted with the Administrator and the Director of Nursing concerning the above. No comments were made.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		8/26/19

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F 582	Continued From page 4 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices were issued to 1 of 39 residents (Resident #43) in the survey sample. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) and Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #43. Resident #43 was discharged from skilled services who remained in the facility with Medicare days remaining. The findings include: Resident #43 was admitted to the facility on	F 582	1. Resident #43 required a NOMNC and ABN to be issued 05/13/19. No immediate correction is possible. 2. All residents discharged from skilled care who remain in the facility with Medicare days remaining are at risk. 3. The Social Workers were inserviced by the Administrator regarding F582 requirements to include issuing a Notice of Medicare Non-Coverage and an Advanced Beneficiary Notice when Medicare A services are terminated on 08/06/19. 4. The Medical Record's clerk will audit 100% of all resident records who have terminated from Medicare Part A services	

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F 582	Continued From page 5 6/30/15 and readmitted on 5/7/19 with diagnoses that included but were not limited to, Type 2 diabetes, urinary retention due to neuromuscular dysfunction of bladder, Alzheimer's disease and chronic kidney disease. Resident #43's most recent MDS (minimum data set) assessment was 5 day scheduled assessment with an ARD (assessment reference date) of 5/14/19. Resident #43 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam. Resident #43 was coded in Section A2400. (Medicare Stay) as receiving skilled services from 5/7/19 through 5/14/19. Review of the facility's list of residents whose Medicare Part A services were discontinued in the last six months with benefit days remaining, revealed that Resident #43's Medicare Part A services were discontinued on 5/15/19. Resident #43 had 92 skilled days remaining at the time of the cut. Evidence that the facility issued an Advanced Beneficiary Notice (ABN) and Notice of Medicare Provider Non-Coverage (NOMNC) letter to Resident #43 was requested from administration. On 7/17/19 at 9:20 a.m., ASM (administrative staff member) #1, the Administrator, stated that staff could not find an ABN and NOMNC letter for Resident #43. When asked who "staff" were, ASM #1 stated that she was referring to the social worker. ASM #1 stated the social worker could not find the letter and therefore could not determine if the letter was given to the resident's representative. On 7/17/19 at 11:38 a.m., an interview was conducted with OSM (other staff member) #6, the social worker. When asked the process for	F 582	and remained in the facility with days available weekly x 8 weeks to assure NOMNC's and ABN's were issued. All audits will be forwarded to the Administrator, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 582	Continued From page 6 issuing ABNs and or NOMNC letters to residents being discharged from Medicare Part A services, OSM #6 stated that she will issue both the ABN and NOMNC letters three days prior to discharge so that the resident has sufficient time to appeal the discharge. OSM #6 stated that the other social worker misplaced the ABN and NOMNC for Resident #43 and that she could not provide evidence that they were issued. On 7/17/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concern. Facility policy titled, "Generic Notice of Medicare Provider Non-Coverage," documents in part, the following: "Skilled Nursing Facilities must provide the Notice of Medicare Provider Non-Coverage (generic notice) to Medicare Beneficiaries No later than 2 days (48 hours) before the effective date of the end of the coverage that their Medicare coverage will be ending."	F 582		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (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;	F 622		8/14/19

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(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a 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.

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F 622	Continued From page 8 (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the resident's care plan to include their goals for 3 of 39 residents in the survey sample (Residents #85, #16 and #75)	F 622	Past noncompliance: no plan of correction required.	

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upon transfer to the hospital. This deficiency is cited as past non-compliance.

The findings included:

1. The facility staff failed to ensure that Resident #85's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/02/19. Resident #85 was originally admitted to the facility on 08/08/2016 and was re-admitted to the facility on 04/17/19. Diagnosis for Resident #85 included but not limited to Hypertension and Hypothyroidism.

A review of nurse's notes dated 4/02/19 reads Phone call to 911 per RP (Responsible Party) would prefer to send resident out to local hospital. Resident resting in bed eyes closed, waiting for arrival of EMT's. MD is aware. At 1820 Resident on LOA (Leave Of Absence) to local hospital. Family will meet resident at the hospital.

An action Plan-Discharge and Bed Hold Notice was received from the administrator on this day. It reads as follows: Date Identified: 05/01/19. Date Certain: 07/05/19. Project Team: IDT. Issue/Concern: F622 Transfer Notice and Bed Hold. Goals/Objectives/Expected Outcome: 1. Provide Bed Hold Notice at time of Transfer. 2. Provide Discharge/Transfer notice at time of transfer. 3. Document items provided to resident/significant other. 4. Include information regarding clinical summary (which includes the care plan and goals) at time of discharge. Correction: All residents experiencing a transfer to ED will be provided a copy of the bed hold policy, transfer notice and clinical summary. Responsible person-Staff nurse. Projected Date:7/2/19. Other Potential: All residents have

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potential to be affected by this deficient practice.
System Changes: 1. Educate Staff on discharge process and documentation requirements. Responsible Person: SDC. Projected Completion Date: 7/5/19. Review Date and Status Report: See education Record 2. Review discharges at daily huddle. Responsible Person: DON. Projected Completion Date: 7/01/19 and ongoing. 3. Review nursing documentation to assure required tools were provided at the time of discharge. Responsible Person: Clinical Manager. Projected Completion Date: 7/01/19 and ongoing 4. SW to provide F/U call to family member to assure information is communicated and determine outcome of bed hold decision. Responsible Person: SW (Social Worker) Projected Completion Date: 7/01/19 and ongoing. 5. Bed Hold policy, transfer notice and clinical summary to be uploaded to EMR. Responsible Person: Medical Records. Projected Completion Date: 7/01/19.
Monitoring/QA Oversight: 1. DON will audit 100% of resident discharges weekly x 3 months for completion of bed hold notification, transfer notice and provision of clinical summary. 2. Analysis of audit will be by the DON to QAPI committee for additional oversight. Responsible person: DON Review Date and Status Report: QA meeting scheduled for 7/16/19.

On 07/18/19 at approximately 3:11 PM an interview was conducted with the Administrator concerning the above issues. The administrator stated that no bed hold notice or care plan summary was sent. She stated that they do have a plan of action in place as of 07/05/19.
2. The facility staff failed to send Resident #16's comprehensive care plan goals when discharged to the hospital on 04/05/2019.

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Resident #16 was admitted to the facility on 08/30/2016. Resident #16 was discharged to the hospital on 04/05/2019 and readmitted to the facility on 04/09/2019. Diagnosis included but were not limited to, Cerebral Palsy and Paraplegia.

On 07/18/2019 at approximately 10:00 a.m., documentation was requested evidencing that the comprehensive care plan goals were sent with Resident #16 upon discharge to the hospital on 04/05/2019. At approximately 2:00 p.m., the facility staff reported that they were unable to provide any documentation evidencing that comprehensive care plan goals were sent with the resident upon discharge to the hospital.

On 07/19/2019 at 4:20 p.m., an interview was conducted with the Administrator and she was asked, "What information do you expect your nurses to send with the resident's upon discharge to the hospital?" The Administrator stated, " I expect the nurses to send the Clinical Summary which includes the care plan goals, Bed Hold Notice and Discharge Summary upon discharge to the hospital." The Administrator stated that the facility had conducted an audit and identified a facility issue with staff not sending the Bed Hold Notice and comprehensive care plan goals with the resident's upon discharge to the hospital. The staff were educated to send the Clinical Summary which includes the care plan and the Bed Hold Notice when discharging the resident to the hospital but they did not do it."

On 07/19/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator and Director of nursing was informed of the finding. The facility did not present any further information about the

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F 622	Continued From page 12	F 622		

finding.
3. The facility staff failed to ensure that Resident #75's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital. Resident #75 went to Programs of All-Inclusive care for the Elderly (PACE) and was transferred to the local hospital and admitted on 04/19/19. Resident #75 was originally admitted to the facility on 05/29/18. Resident #75 was re-admitted to the facility on 04/24/19. Diagnosis for Resident #75 included but not limited to Dementia with behavioral disturbances.

On 04/19/19, according to the facility's documentation, the facility's nursing staff received a phone call from Programs of All-Inclusive care for the Elderly (PACE) on 04/19/19. The documentation read; PACE clinic called at 1:30 p.m., to inform that they were sending Resident #75 to the local hospital due to him sleeping a lot, the podiatrist feels he may be septic. The Resident returned to the facility on 04/24/19.

On 07/17/19 at approximately 4:10 p.m., the Administrator stated there was no evidence the care plan information was sent upon discharge or shortly after being discharged to the hospital for 4/19/19.

An interview was conducted with the clinical manager on 07/18/19 at approximately 10:13 a.m. The surveyor asked, "After Resident #75 was sent to the local hospital and admitted on 04/19/19, was the Resident's care plan to include their goals either faxed or delivered to the hospital." The clinical manager replied, "I was unable to locate documentation that the care plan was issued in the resident's clinical record." She said the care plan should have been either faxed

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F 622	Continued From page 13 or delivered once we realized that Resident #75 was sent to the hospital. The surveyor asked, "What is the purpose for sending the resident person-centered care plan, she replied, "To maintain continuity of care, that way they know what we are doing here and the same care can be provided at the hospital." On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The facility did not present any further information about the finding. The facility's policy titled Life Care-Transfer, Discharge & Room Change (Social Services) reviewed date of 08/15/18. The discharge care plan is part of the comprehensive care plan and must included but not limited to: -Address goals of care and treatment preferences.	F 622		
F 625 SS=D	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;	F 625		8/14/19

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F 625	Continued From page 14 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed to provide the resident or resident's representative a copy of the bed hold policy upon discharge/transfer to the hospital for 3 of 39 residents (Resident #85, #16 and #75 after being transferred to the hospital. This deficiency is cited as past non-compliance. The findings included: 1. The facility staff failed to issue the resident/representative with a written copy of bed hold policy for Resident #85. Resident #85 was transferred to the local hospital and admitted on 04/02/19. Resident #85 was originally admitted to the facility on 08/08/2016 and was re-admitted to the facility on 04/17/19. Diagnosis for Resident #85 included but not limited to Hypertension and Hypothyroidism.	F 625	Past noncompliance: no plan of correction required.	

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Resident #85's current Minimum Data Set (MDS), a quarterly revision with an Assessment Reference Date (ARD) of 02/13/19 coded the resident with a 07 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment.

The Discharge MDS assessment dated 04/02/19 - discharge return anticipated, resident re-admitted on 04/17/19.

A review of nurse's notes dated 4/02/19 reads Phone call to 911 per RP (Responsible Party) would prefer to send resident out to local hospital. Resident resting in bed eyes closed, waiting for arrival of EMT's. MD is aware. At 1820 Resident on LOA (Leave Of Absence) to local hospital. Family will meet resident at the hospital.

On 07/18/19 at approximately 3:11 PM an interview was conducted with the Administrator concerning the above issues. The Administrator stated that no bed hold notice was sent. She stated that they do have a plan of action in place as of 07/05/19.

An action Plan-Discharge and Bed Hold Notice was received from the administrator on this day. It reads as follows: Date Identified: 05/01/19. Date Certain: 07/05/19. Project Team: IDT. Issue/Concern: F622 Transfer Notice and Bed Hold. Goals/Objectives/Expected Outcome: 1. Provide Bed Hold Notice at time of Transfer. 2. Provide Discharge/Transfer notice at time of transfer. 3. Document items provided to resident/significant other. 4. Include information regarding clinical at time of discharge. Correction: All residents experiencing a transfer to ED will be provided a copy of the bed hold policy, transfer

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notice and clinical summary. Responsible person-Staff nurse. Projected Date:7/2/19. Other Potential: All residents have potential to be affected by this deficient practice. System Changes: 1. Educate Staff on discharge process and documentation requirements. Responsible Person: SDC. Projected Completion Date: 7/5/19. Review Date and Status Report: See education Record 2. Review discharges at daily huddle. Responsible Person: DON. Projected Completion Date: 7/01/19 and ongoing. 3. Review nursing documentation to assure required tools were provided at the time of discharge. Responsible Person: Clinical Manager. Projected Completion Date: 7/01/19 and ongoing 4. SW to provide F/U call to family member to assure information is communicated and determine outcome of bed hold decision. Responsible Person: SW (Social Worker) Projected Completion Date: 7/01/19 and ongoing. 5. Bed Hold policy, transfer notice and clinical summary to be uploaded to EMR. Responsible Person: Medical Records. Projected Completion Date: 7/01/19.
Monitoring/QA Oversight: 1. DON will audit 100% of resident discharges weekly x 3 months for completion of bed hold notification, transfer notice and provision of clinical summary. 2. Analysis of audit will be by the DON to QAPI committee for additional oversight. Responsible person: DON Review Date and Status Report: QA meeting scheduled for 7/16/19.

On 7/18/19 at approximately 4:12 PM a pre-exit interview was conducted concerning the above issues. The Administrator and Director of Nursing were present.
2. The facility staff failed to provide Resident #16 a written Bed Hold Notice when discharged to the hospital on 04/05/2019.

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Resident #16 was admitted to the facility on 08/30/2016. Resident #16 was discharged to the hospital on 04/05/2019 and readmitted to the facility on 04/09/2019. Diagnosis included but were not limited to, Cerebral Palsy and Paraplegia. Resident #16's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/16/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #16 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, toilet use and personal hygiene and independent in eating with set up help only.

On 07/18/2019 at approximately 10:00 a.m., documentation was requested evidencing that the written Bed Hold Notice was sent with or provide to Resident #16 upon discharge to the hospital on 04/05/2019. At approximately 2:00 p.m., the facility staff reported that they were unable to provide any documentation evidencing that the written Bed Hold was sent with or provided to the resident upon discharge to the hospital.

On 07/19/2019 at 4:20 p.m., an interview was conducted with the Administrator and she was asked, "What information do you expect your nurses to send with the resident's upon discharge to the hospital?" The Administrator stated, " I expect the nurses to send the Clinical Summary which includes the care plan goals, Bed Hold Notice and Discharge Summary upon discharge to the hospital."
The Administrator stated that the facility had conducted an audit and identified a facility issue with staff not sending the Bed Hold Notice and

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comprehensive care plan goals with the resident's upon discharge and the staff had been educated to send them but they did not do it."

On 07/19/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator and Director of nursing was informed of the finding. The facility did not prevent any further information about the finding.

3. Resident #75 went to Programs of All-Inclusive care for the Elderly (PACE) and was transferred to the local hospital and admitted on 04/19/19. Resident #75 was originally admitted to the facility on 05/29/18. Resident #75 was re-admitted to the facility on 04/24/19. Diagnosis for Resident #75 included but not limited to *Dementia with behavioral disturbances.

Resident #75's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 06/24/19 coded the resident with a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making.

The Discharge MDS assessments was dated for 04/19/19-discharge return anticipated.

On 04/19/19, according to the facility's documentation, the facility's nursing staff received a phone call from Programs of All-Inclusive care for the Elderly (PACE) on 04/19/19. The documentation read; PACE clinic called at 1:30 p.m., to inform that they were sending Resident #75 to the local hospital due to him sleeping a lot, the podiatrist feels he may be septic.

On 07/17/19 at approximately 4:10 p.m., the

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Administrator stated there was no evidence the bed hold information was sent upon discharge or shortly after being discharged to the hospital for 4/19/19.

An interview was conducted with the clinical manager on 07/18/19 at approximately 10:13 a.m. The surveyor asked, "After Resident #75 was sent to the local hospital and admitted on 04/19/19, was the bed hold policy either faxed or delivered to the hospital?" The clinical manager replied, "I am unable to locate documentation that the bed hold policy was ever issued in the resident's clinical record." She said the bed hold policy should have been either faxed or delivered once we realized that Resident #75 was sent to the hospital. The surveyor asked, "What is the purpose for issuing the bed hold policy" she replied, "To see if the family would like to hold the residents bed."

On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The facility did not present any further information about the finding.

The facility's policy titled Life Care - Bed Hold (Last revision: 12/19/18.)
-Policy statement: It is the facility policy to inform the resident or resident representative of the durations of the bed-hold policy, if any, during which the resident is permitted to return and resume residence when admitted to an acute care facility or goes on therapeutic leave.

-Resident or Resident Representative will be provided a "Notice of Bed Hold Policy" letter at time of transfer, if not immediately possible,

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F 625	Continued From page 20 notification will be a first available opportunity. -Notice of bed hold policy will be provided with transfer documents.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical review, the facility failed to complete a significant change assessment for 1 of 39 residents (Resident #39), in the survey sample, after being discharged from Hospice services. The findings included: Resident #39 was originally admitted to the facility on 07/08/17. Diagnosis for Resident #39 included but not limited to, Alzheimer's disease and Dementia without behavioral disturbances. Resident #39's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/22/19 coded Resident #39 with short and long-term memory problems and cognitive skills severely impaired-never/rarely	F 637	1. A comprehensive assessment was completed for resident #39 on 07/29/19. 2. All residents discharging from Hospice services are at risk. 3. IDT staffs were inserviced by the Administrator on F637 requiring a comprehensive assessment when a resident is discharged from Hospice services 08/08/19. 4. The Social Worker will audit 100% of residents discharged from Hospice services x 8 weeks to assure a comprehensive assessment has been scheduled/completed. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional	8/19/19

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made decisions. Resident #39 under section O-Special Treatments and Programs was coded for Hospice Care.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 07/17/19 at approximately 1:02 p.m., who said Resident #39 has had a big improvement; she was recently discharged from hospice care on 05/22/19. Review of the clinical record did not show evidence that a significant change assessment was completed. Review of the clinical record showed evidence that Resident #39 was admitted to hospice care on 02/22/19. The resident was discharged from hospice care on 05/22/19.

An interview was conducted with the Clinical Manager on 07/18/19 at approximately 10:06 a.m. When asked, "When Resident #39 was discharged from hospice services, did that change require a significant change MDS to be completed?" The Clinical Manager replied, "I'm not sure, check with the MDS Coordinator."

On 07/18/19 at approximately 11:10 a.m., an interview was conducted with the MDS Coordinator. The surveyor asked, "When a resident is discharged from hospice services, should a significant change assessment be completed." The MDS Coordinator stated, "Yes, a significant change MDS should been done within 14 days after the resident was discharged from hospice services." The surveyor asked, "What references do you use to determine when a significant change assessment needs to be completed" she replied, "We go by the Resident Assessment Instrument (RAI) manual." On the same day at 11:53 a.m., the MDS Coordinator presented the surveyor a form titled: CMS's RAI

oversight.

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F 637	Continued From page 22 Version 3.0 Manual. The following information was included: On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The facility did not present any further information about the finding. 0.3 Significant Change in Status Assessment (SCSA): -A SCSA is required to be performed when a resident is receiving hospice services and then decides to be discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following but not limited to; The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for a SCSA are met (determination date + 14 calendar days). Definitions: *Hospice Care is a system of family-centered care designated to assist the terminally ill person to the be comfortable and to maintain a satisfactory life-style through the phases of dying (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review and staff interviews the facility	F 641	A discharge assessment for resident #84 was corrected and submitted on 07/18/19.	8/19/19

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F 641	Continued From page 23 staff failed to ensure that the discharge Minimum Data Set Assessment was accurate for 1 of 39 resident in the survey sample, Resident #84. The findings included : Resident #84's discharge Minimum Data Set Assessment dated 4/17/19 was coded as the resident was discharged to the hospital when in fact he was discharged home. Resident #84 was admitted to the facility on 4/2/19 with diagnoses to include but not limited to Diabetes Mellitus and Hypertension. Resident #84 was discharged home on 4/17/19. The most recent comprehensive Minimum Data Set (MDS) Assessment was an Admission 5-Day with an Assessment Reference Date (ARD) of 4/9/19. The Brief Interview for Mental Status for Resident #84 was coded as a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #84's Physician Discharge Summary dated 4/17/19 was reviewed and is documented in part, as follows: NH (Nursing Home) Course: Resident seen for preparation discharge today. He has met goals with therapy and today is discharging to home. Resident #84's Clinical Note dated 4/17/19 was reviewed and is documented in part, as follows: Pt. (patient) discharged with all medications and signed documentation at this time. Transported by wheelchair with sister.	F 641	2. All residents who have a discharge assessment completed are at risk. 3. IDT staffs were inserviced by the Administrator on F641 requiring Minimum Data Set assessments to accurately reflect the location of a resident at discharge on 08/07/19. 4. The Social Worker will audit 100% of all residents discharged x 8 weeks to assure the correct discharge location has been selected on the MDS. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 641	Continued From page 24 Resident #84's Discharge MDS Assessment with an ARD date of 4/17/19 was reviewed and is documented in part, as follows: Section A Identification Information A2000. Discharge Date: 4/17/19 A2100. Discharge Status: 03-Acute Hospital On 7/18/19 at 11:38 A.M. an interview was conducted with the MDS Coordinator regarding Resident #84's Discharge MDS with the ARD of 4/17/19. The MDS Coordinator was shown the Physician Discharge Summary, the Clinical Note and the Discharge MDS all dated 4/17/19. The MDS Coordinator stated, "The MDS is incorrect the resident did not go tot he hospital, he went home. I will have to do a modification of the MDS to show he went home. The MDS should report the information about the resident accurately." The MDS Coordinator was asked if there was a policy for ensuring that MDS's are accurate. The MDS Coordinator stated, "We follow the RAI (Resident Assessment Instrument) 3.0 Manual." On 7/18/19 at approximately 4:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		8/19/19

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F 655	Continued From page 25 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility	F 655	1. The baseline care plan for resident	

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F 655	Continued From page 26 document review and staff interviews the facility staff failed to ensure a Baseline Care Plan addressed hemo-dialysis for 1 of 39 residents in the survey sample, Resident #237. The findings included: Resident #237 was admitted to the facility on 7/12/19 with diagnoses to include but not were limited to, Chronic Kidney Disease and Dependence on Renal Dialysis. Resident #237 was a new admission and the comprehensive Admission Minimum Data Set Assessment and Comprehensive Care Plan has not yet been completed. The resident's baseline care plan was reviewed, however the resident requiring hemo-dialysis was not included. Resident #237's Hospital Discharge Summary dated 7/12/19 was reviewed and is documented in part, as follows: Discharge Diagnoses: ESRD (end stage renal disease) on PD (peritoneal dialysis) now HD (hemo-dialysis). Resident #237's Treatment Administration Record was reviewed and is documented in part, as follows: Dialysis Three Times Weekly Starting 7/12/19. Order Date: 7/12/19 Notes Monday and Thursday at 9:30 A.M. then Tuesday, Thursdays and Saturdays. Resident was signed off by nursing as going to dialysis on 7/12/19 and 7/16/19.	F 655	#237 did not address dialysis. No immediate correction is possible. A comprehensive care plan for resident #237 was completed on 07/24/19 which included hemodialysis as an identified care need. 2. All residents on dialysis are at risk. 3. 100% of licensed nursing staffs will be inserviced on Sentara Life Care procedure entitled Baseline Care Plan which includes instructions on a free text field for items such as dialysis that do not automatically populate 08/06/19-08/16/19. 4. The Clinical Manager, or designee, will audit all baseline care plans for residents admitted on dialysis x 8 weeks to assure it accurately reflects care needed for dialysis. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 655	Continued From page 27 On 7/17/19 at 4:34 P.M. an interview was conducted with the Director of Nursing regarding Resident #237's Baseline Car Plan. The Director of Nursing was asked if hemo-dialysis has been included in Resident #237's Baseline Care Plan and if not should it had been and why. The Director of Nursing stated, "No, it was not on the baseline care plan. It should have been included to provide person-centered care for the resident, it was added on 7/16/19." The facility policy titled "Baseline Care Plan" revised 11/21/17 was reviewed and is documented in part as follows: Policy Statement: It is the policy of the facility to develop and implement a baseline care plan for each resident to include the instructions needs to provide a person-centered care plan. It is the standard of the facility to have developed within 48 hours of the residents' admission the baseline care plan. On 7/18/19 at approximately 4:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 655		
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	F 656		8/19/19

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F 656	Continued From page 28 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview and clinical record review the facility staff failed to include pain management in the comprehensive care plan, for 1 of 39 resident's in	F 656	1. The comprehensive care plan for resident #77 was updated on 07/18/19 to reflect pain management. 2. All residents experiencing pain are at	

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F 656	Continued From page 29 the survey sample (Resident #77). The findings included: Resident #77 was admitted to the facility on 06/18/2019. Diagnoses included but were not limited to, Fracture of Left Femur and Cancer. Resident #77's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 06/25/2019 coded the resident with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #77 as requiring extensive assistance of 1 for bed mobility and toilet use, extensive assistance of 2 for transfer, limited assistance of 1 for dressing and independent in eating and personal hygiene with set up help only. On 07/17/2019 at 5:50 p.m., an interview was conducted with Resident #77 and she was asked, "Do you ever have any pain?" Resident #77 stated, "Yes, in my left leg and hip where I fractured my hip." Resident #77 was asked, "Do you receive pain medication for your pain?" Resident #77 stated, "Yes." Resident #77 was asked, "Is the medication effective?" Resident #77 stated, "Yes." On 07/18/2019 Resident #77's clinical record was reviewed and revealed the following Physician Orders in June 2019 and July 2019: Robaxin-750 750 mg (milligrams). (1 tablet) three times daily starting on 06/18/2019 for pain; Hydrocodone 5 mg -acetaminophen 325 mg (1 tab) Tablet oral as needed every six hours for pain starting on 06/18/2019 and Hydrocodone 5 mg-acetaminophen 325 mg tablet (2 tab) Tablet oral as needed every six hours for pain starting	F 656	risk if a comprehensive care plan is not developed. 3. MDS/Care Planning staffs will be inserviced on the care planning process noted in the RAI Manual Chapter 4 which addresses the Care Area CAA) Summary process and care planning decisions 08/06/19-08/16/19. 4. The Manager of Quality Development, or designee, will audit all comprehensive assessments x 8 weeks to assure all CAA's have been addressed on the care plan. All audits will be forwarded to the Administrator, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 656	Continued From page 30 on 06/18/2019; Gabapentin 100 mg. capsule (1 cap) oral at hour of sleep for pain starting on 07/17/2019. Resident #77's comprehensive care plan was reviewed and failed to evidence that pain management was addressed in the care plan. On 07/18/2019 at approximately 10:32 a.m., an interview was conducted with the MDS Coordinator and she was asked, "Is pain management addressed in Resident #77's comprehensive care plan?" The MDS Coordinator stated, "No, but it should have been care planned." The MDS Coordinator was asked, "What is the purpose of the comprehensive care plan?" The MDS Coordinator stated, "The purpose it to provide an overall picture of the resident's needs. It provides the staff with interventions and how to care for the resident." On 07/19/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator and Director of Nursing was informed of the finding. The facility did not present any further information about the finding.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		8/19/19

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F 657	Continued From page 31 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: #3. The facility staff failed to revise the comprehensive care plan for Resident #5 to include an indwelling Foley catheter. Resident #5 was admitted to the facility on 6/30/19 with diagnoses to include, but not limited to cervical spine (neck) surgery, and generalized weakness. The current MDS (Minimum Data Set) a 5 day admit with an assessment reference date of 7/7/19, coded the resident as scoring a 14 out of a 15, indicating the residents cognition was intact. The resident was coded as always incontinent under section H. Bowel and Bladder and required extensive assistance of two staff for toileting. Review of the clinical notes entered 7/12/19 at 12:15 a.m. evidenced the following, "Distended pelvis region reported by CNA (certified nurse	F 657	1. Resident #5 foley catheter was discontinued on 07/18/19. No immediate correction to her care plan is possible. Resident #39 care plan was revised on 07/30/19 to reflect the discontinuation of an antianxiety medication. Resident #52 care plan was revised on 08/02/19 to reflect the discontinuation of hypnotic and antianxiety medications. 2. All residents are at risk if comprehensive care plans are not revised as needed. 3. 100% of licensed nursing staffs will be inserviced on Sentara Life Care policy entitled Comprehensive Care Plan to include staff participation in the care planning process and required revisions on 08/06/19-08/16/19. 4. The Clinical Manager, or designee, will	

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F 657	Continued From page 32 assistant), bladder scan completed and reading was 787 ml (milliliters). Pt straight cath and 800 cc was collected. MD made aware and gave new order for Foley to be placed. 18 F (French) with 10 cc balloon in place and anchored to LT (left) thigh. Foley is patent and draining light amber urine...". A Foley catheter is a thin, sterile tube inserted into the bladder to drain urine. Reference www.NIH.gov (National Institutes of Health). On 7/16/19 at approximately 5:15 p.m., and on 7/17/19 at 10:45 a.m., the resident was observed to have an indwelling Foley catheter. Resident #5's comprehensive care plan with an effective date of 7/8/19 was reviewed on 7/17/19. The care plan was not revised to include the Foley catheter. On 07/17/19 at 5:08 p.m., an interview with Registered Nurse (RN) #3, Great Bridge Pavilion unit manager, was conducted. He was asked to review the resident's care plan. When asked if there was a care plan for the Foley catheter he stated, "I don't see anything here for a Foley." When asked if the care plan should have been revised to include the Foley catheter, he stated, "Yes." The unit manager further stated that it is the responsibility of the nurse who implemented the order to have revised the care plan. On 7/19/19 at 2:13 p.m., the above findings was shared with the Administrator and the Director of Nursing. The Administrator agreed that the care plan should have been revised to include the Foley catheter.	F 657	review the 24 hour report daily x 8 weeks to assure necessary care plan updates have been added. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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No additional information was provided to the survey team prior to exit.

Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise the comprehensive personal centered care plan for 3 (Resident #39, #52 and #5) of 39 residents in the survey sample.

The findings included:

1. The facility staff failed to revise Resident #39's comprehensive person centered care plan to include the discontinuation use of the antianxiety medication, Ativan.

Resident #39 was originally admitted to the facility on 07/08/17. Diagnoses for Resident #39 included but was not limited to, *Anxiety disorder. Resident #39's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/22/19 coded Resident #39 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

Review of Resident #39's person centered care plan with a revision date of 05/30/19 had a problem which read: resident is receiving antianxiety drugs on a regular basis. The goal read: symptoms of anxiety will be controlled with minimal side effects over the next 90 days. Interventions included monitor for side effects of medication and to notify the physician if side effects noted.

Review of Resident #39's current Physician Order

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Sheet (POS) for July 2019, did not include medication for the treatment of anxiety.

An interview was conducted with the Clinical Manager on 07/18/19 at approximately 10:00 a.m. She reviewed Resident #39's discontinued medication. She said Resident #39 was started on Ativan 1 mg tablet as needed four times daily for anxiety with a discontinuation date of 04/26/19. The surveyor asked, "Should Resident #39's person-centered care plan still read that she is receiving antianxiety medication, she replied, "No, the care plan should have been revised." She said the order was for *Ativan prn (as needed) and not scheduled per the care plan. The surveyor asked, "Who is responsible for updating/revising the resident's care plan" she replied, "The nurses, MDS Coordinator as well as myself." The surveyor asked, "What is the purpose of having an accurate care plan" she replied, "To make sure the resident is receiving the proper care."

On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The facility did not present any further information about the finding.

Definitions:

*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).

*Ativan is used to relieve anxiety

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(www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html).

2. The facility staff failed to revise Resident #52's comprehensive person centered care plan to include the discontinuation use of a hypnotic and anti-anxiety medication.

Resident #52 was originally admitted to the facility on 09/07/16. Diagnosis for Resident #52 included but not limited to *Insomnia and *Anxiety disorder. Resident #52's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/29/19 coded Resident #52 with a 02 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making.

Review of Resident #52's person centered care plan with a revision date of 06/05/19 had a problem, which read: to receive hypnotic medication to aid with insomnia. The goal read: minimize/avoid harmful side effects during the next review. Interventions included: Administer medication as ordered, notify physician if resident appears to be drowsy or shows decrease in usual functioning and monitor for side effects. The care plan also had a problem, which read: Resident is receiving antianxiety drugs on a needed basis r/t (related to) anxiety. The goal read: symptoms of anxiety will be controlled with minimal side effects. One of the interventions included to monitor for side effects of medication.

During the review of Resident #52's current Physician Order Sheet (POS) for July 2019, did not include medication for the treatment of anxiety or insomnia.

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An interview was conducted with the Clinical Manager on 07/18/19 at approximately 10:00 a.m. She reviewed Resident #52's discontinued medication. She said Resident #52 was started on *Ativan 1 mg tablet every 6 hours as needed for anxiety with a start date of 09/07/16 and a discontinued date of 04/10/17. She also said the resident was started on *Ambien 10 mg daily at bedtime for insomnia with a start date of 09/22/17 with a stop date of 06/26/18. The surveyor asked, "Should Resident #52's person-centered care plan still read that she is receiving antianxiety and hypnotic medication, she replied, "No, the care plan should have been revised." The surveyor asked, "Who is responsible for updating/revising the resident's care plan" she replied, "The nurses, MDS Coordinator as well as myself." The surveyor asked, "What is the purpose of having an accurate care plan" she replied, "To make sure the resident is receiving the proper care."

On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The facility did not present any further information about the finding.

Definitions:

*Insomnia is a common sleep disorder; you may have trouble falling asleep, staying asleep, or both (https://medlineplus.gov/ency/article/007365.htm).

*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you

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F 657	Continued From page 37 are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). *Ativan is used to relieve anxiety (www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html). *Ambien is used to treat insomnia (difficulty falling asleep or staying asleep) (https://medlineplus.gov/ency/article/007365.htm).	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and review of the facility's policy, the facility staff failed to ensure the necessary treatment, care and services were provided to prevent further development or worsening of, a facility acquired *pressure ulcer for 1 of 39 residents (Resident #75) in the survey sample. The facility staff failed to notify the physician of the podiatrist's recommendation written on 07/01/19 for the use of prevalon boots for a resident with an *unstageable left heel pressure ulcer. The findings included: Resident #75 was admitted to the facility on	F 658	1. A clarification order for the use of Prevalon boots was obtained for resident #75 on 07/23/19. 2. All residents are at risk if assistive devices (when indicated) are not provided to facilitate wound healing. 3. All licensed nursing staffs will be inserviced on the process for follow up when MD orders are unclear or incomplete, and the provision of assistive devices to promote healing of pressure ulcers 08/06/19-08/16/19. 4. The Clinical Manager's will review 4 pressure ulcers weekly x 8 weeks to assure all measures to promote wound healing have been initiated. Wound interventions will be reviewed weekly by	8/19/19

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F 658	Continued From page 38 05/29/18. Diagnosis for Resident #75 included but are not limited to *Dementia with behavioral disturbance and Involuntary Mobility (not done by choice; done unwillingly). Resident #75's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 06/24/19 coded the resident with a 5 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making. In addition, the MDS coded Resident #75 as requiring total dependence of one with bathing, extensive assistance of two with bed mobility, transfer and personal hygiene, extensive assistance of one with dressing, eating and toilet use. The MDS with an ARD of 06/24/19 under section "M" (Skin Condition-M0100) was coded: Resident has a stage 1 or greater pressure ulcer. Under section (M0150) at risk for developing pressure ulcers was coded: yes, under section (M0210) for unhealed pressure ulcers was coded: yes, under section (M0300) for having unstageable (1) pressure ulcer was coded: yes. Under section (M1200) for skin and treatments it was coded for having pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems and pressure ulcer care. Resident #75's person-centered comprehensive care plan documented Resident #75 with actual skin breakdown to left heel (ulcer). The goal: ulcer will not worsen during the next 90 days. Some of the intervention/approaches to manage goal included to provide care according to physician orders-see Treatment Administration Record (TAR), use pressure reducing mattress	F 658	the DON during the Standards of care meeting. All wound reviews will be summarized by the DON, and presented to the QAPI committee for recommendations and additional oversight.	

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and use pillows, pads, or wedges to reduce pressure on heels and provide care according to physician orders.

A Braden Risk Assessment Report was completed on 01/02/19; resident scored a 16 indicating mild risk for the development of pressure ulcers with Friction and Shear as a potential problem.

During the initial tour of the facility on 07/16/19 at approximately 4:32 p.m., Resident #75 was observed in bed lying on his right side with his heels position directly on the mattress. A pair of prevalon boots were observed on the floor beside Resident #75's nightstand.

On 07/17/19 at approximately 2:05 p.m., Resident #75's bilateral heels were observed positioned directly on the mattress and a pair prevalon boots were observed on the over bed table.

Resident #75's progress note written by the podiatrist on 07/01/19 revealed the following documentation:
Assessment: Wagner Stage 1 Ulcer to left heel (Staging the seriousness of a diabetic foot ulcers; Stage 1=ulcer is present but no infection. www.healthline.com).
Plan: He needs to wear a Prevalon boot on both feet.
Vascular Exam: Within Normal Limits to left foot.
Integument/Skin: Ulcer posterior left heel with stable eschar.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 07/17/19 2:10 p.m. The surveyor asked, "Since Resident #75 has an unstageable pressure ulcer to his left heel, when

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should the prevalon boots to be applied?" The LPN replied, "I cannot answer that; how Resident #75 is to wear the prevalon boots is up to PACE, they approve all orders for Resident #75." The LPN looked in the computer for the order on how and when Resident #75 is to wear the prevalon boots. After the LPN finished looking for the prevalon boot order she replied, "I do not see an order for prevalon boots." She said "I will call PACE for clarification on when Resident #75 is to wear the prevalon boots and get back with you."

An interview was conducted with certified nursing assistant (CNA) #1 on 07/17/19 at approximately 2:20 p.m. The surveyor asked "When does Resident #75 wear his prevalon boots" she replied , "I removed them when he goes to bed but put them back on when I get him out of the bed." The surveyor asked, "When is Resident #75 to wear his prevalon boots" she replied, "I really do not know." The surveyor asked, "Were you ever told when to apply the prevalon boots" she replied, "No." The surveyor asked, "What is the purpose of prevalon boots, she replied, "To take the pressure of the heels and ankles." The surveyor asked, "Is the pressure being relieved when the resident is in bed without his prevalon boots on, she replied "No."

The Administrator and Director of Nursing (DON) were informed of the finding during a briefing on 07/18/19 at approximately 2:20 p.m. The surveyor informed the Administrator and DON the *podiatrist made a recommendation on 07/01/19 for the use of prevalon boot due to an unstageable left heel pressure but the nursing staff was unable to show evidence that PACE was ever made aware. The DON said, "PACE should have received the podiatrist

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recommendation and they (PACE) should have either approved or declined the recommendation." The surveyor asked, "What is the purpose of prevalon boots." The DON stated, "To give off load to the heels; the prevalon boots form as a cradle to keep the heels from touching the bed." On the same day at approximately 5:35 p.m., the DON presented a physician order sheet signed by the PACE physician that read: "Podiatry note from 07/01/19 reviewed; agree with order for prevalon boots to be worn on both feet. Boots to be worn at all times except for cleaning and care."

Definitions:

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

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar

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F 658	Continued From page 42 (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/) . *Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia (https://www.ncbi.nlm.nih.gov/pubmed/22644311) . *Prevalon (boots) helps minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals. By off-loading the heel, it delivers total, continuous heel pressure relief (www.hdis.com/prevalon-boot-heel-protector.html). *Podiatrist is a health professional who diagnoses and treats disorders of the feet (Mosby's Dictionary of Medicine, Nursing & Health Professions).	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/26/19

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F 684	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and review of the facility's policy, the facility staff failed to ensure the necessary treatment, care and services were provided to promote healing, prevent infection and to prevent development of new foot ulcer for 1 of 39 residents (Resident #75) in the survey sample. The findings included: The facility staff failed to prevent, identify, and treat Resident #75's foot ulcer to the back of left heel prior to being found at an advance stage (unstageable) resulting in harm. The ulcer was first identified as a black crusty scabbed measuring 2 cm x 2 cm. Resident #75 was admitted to the facility on 05/29/18. Diagnoses for Resident #75 included, but were not limited to *Dementia with behavioral disturbance, *Diabetes Mellitus and involuntary movements (not done by choice; done unwillingly). Resident #75's quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 06/24/19 coded a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making. In addition, the MDS coded Resident #75 requiring total dependence of one with bathing, extensive assistance of two with bed mobility, transfer and personal hygiene, extensive assistance of one with dressing, eating and toilet use. Under section "M" (Skin Condition - M0100) of the MDS, it was coded: Resident has a stage 1	F 684	1. Resident #75 was evaluated by the podiatrist on 08/01/19. He is noted with stable eschar to the posterior left heel. The ulcer is covered with Allevyn for protection. His heel is off-loaded utilizing a Prevalon Boot at all times except when providing care. 2. All residents are at risk if ulcers are not identified timely so more immediate treatment can be provided. 3. All residents have been assessed for any new ulcers as of 08/19/19 and treatment initiated if indicated. 100% of all nursing staffs will be inserviced on Sentara Life Care policies entitled RN/LPN Guidelines for Skin Integrity and CNA Guidelines for Skin Integrity which includes weekly skin checks, reporting impaired skin integrity, off-loading heels, use of assistive devices and other preventative techniques 08/06/19-08/22/19. 4. The Clinical Managers, or designee, will complete a skin assessment on 5 residents per week x 8 weeks to assure prompt and accurate identification of ulcers. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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or greater pressure ulcer. Section (M0150) at risk for developing *pressure ulcers was coded: yes; Section (M0210) for unhealed pressure ulcers was coded: yes; Section (M0300) for having *unstageable (1) pressure ulcer was coded: yes. Section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems and pressure ulcer care.

Resident #75's person-centered comprehensive care plan revised 7/16/19 documented Resident #75 with actual skin breakdown to left heel diabetic ulcer. The goal: ulcer will not worsen during the next 90 days. Some of the intervention/approaches to manage goal included to provide care according to physician orders-see Treatment Administration Record (TAR), use pressure reducing mattress and use pillows, pads, or wedges to reduce pressure on heels and pressure points (turn/reposition), assess and record the size (L x W x D) of skin discoloration, edema and pain status. There were no preventative measures in place prior to the development of the unstageable ulcer.

A Braden Risk Assessment Report was completed on 01/02/19; resident scored a 16 indicating mild risk for the development of pressure ulcers.

During the initial tour of the facility on 07/16/19 at approximately 4:32 p.m., Resident #75 was observed in bed lying on his right side with his heels position directly on the mattress. A pair of prevalon boots were observed on the floor beside Resident #75's nightstand.

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Review of the clinical record revealed the current treatment to the left heel as of 07/12/19 read as follows: Cleanse with normal saline gauze, dry area after cleaning, apply allevyn dressing; dressing to be changed every other day.

Review of the Treatment Administration Record (TAR) for July 2019 revealed on 07/06/19, the treatment was not completed for late afternoon or evening shift due to Resident #75 not being cooperative, moving left/foot all over and yelling at nurse.

On 07/17/19 at approximately 11:00 a.m., wound care observation was conducted with Licensed Practical Nurse (LPN) #1. Resident #75 was lying in bed on his right side. Prior to starting wound care, LPN #1 washed her hands x 21 seconds and donned a pair of gloves. The LPN removed the old dressing from the left heel wound. The left heel pressure ulcer was observed with black *eschar (hard black dead tissue) with red peri wound edges, no drainage or odor noted. The wound was cleaned with saline soaked gauze x 2; gloves removed, hand sanitizer applied, a new pair of gloves donned. The LPN measured left heel wound; area measured at 4 cm x 2.5 cm, gloves removed, hand sanitizer applied, donned new glove then applied allevyn dressing. Through the entire dressing change, Resident #75 was thrashing his left leg/foot around with his left heel rubbing continuously on the mattress.

On 07/17/19 at approximately 2:05 p.m., Resident #75's bilateral heels were observed positioned directly on the sheet/mattress and a pair prevalon boots were observed on the over bed table.

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The review of the clinical nurse note evidenced an entry dated 04/30/19 at 10:35 a.m., written by LPN #1 indicated the following: "Resident kicking left shoe off. Noted 2 cm x 2 cm black crusty scabbed area to back of heel, area cleanse with normal saline dermal wound cleanser (DWC) and skin prep applied, no drainage present. Reached out to Programs of All-Inclusive care for the Elderly (PACE) concerning the wound to back of left heel." On the same day at approximately 11:09 a.m., a clinical note written by LPN #1 indicated the following documentation: Follow-up with PACE related to ulcer to left heel and the Nurse Practitioner (NP) from PACE will be in this afternoon to evaluate Resident #75's foot.

Resident #75's progress note written by the podiatrist on 07/01/19 revealed the following documentation:
Assessment: Wagner - Stage 1 Ulcer to left heel. (Staging the seriousness of a diabetic foot ulcers; Stage 1=ulcer is present but no infection. www.healthline.com).
Plan: He needs to wear a Prevalon boot on both feet.
Vascular Exam: Within Normal Limits (WNL) to left foot.
Integument/Skin: Ulcer posterior left heel with stable eschar.
The progress note included: Patient presents to the office on 07/01/19 for Annual Diabetic Foot Exam and foot care. Patient was brought in by care giver from PACE.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 07/17/19 2:10 p.m. The surveyor asked, "Since Resident #75 has an unstageable ulcer to his left heel, when should the prevalon boots to be applied?" The LPN

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replied, "I cannot answer that; how Resident #75 is to wear the prevalon boots is up to PACE, they approve all orders for Resident #75." The LPN looked in the computer for the order on how and when Resident #75 is to wear the prevalon boots. After the LPN finished looking for the prevalon boot order she replied, "I do not see an order for prevalon boots." She said; I will call PACE for clarification on when Resident #75 is to wear the prevalon boots and get back with you.

An interview was conducted with CNA #1 on 07/17/19 at approximately 2:20 p.m. The surveyor asked "When does Resident #75 wear his prevalon boots" she replied , "I removed them when he goes to bed but put them back on when I get him out of the bed." The surveyor asked, "When is Resident #75 to wear his prevalon boots" she replied, "I really do not know." The surveyor asked, "Were you ever told when to apply the prevalon boots" she replied, "No." The surveyor asked, "What is the purpose of prevalon boots, she replied, "To take the pressure of the heels and ankles" the surveyor asked, "Is the pressure being relieved when the resident is in bed without his prevalon boots on, she replied "No."

On 07/18/19 at approximately 2:20 p.m., the above information was shared with the Administrator and the Director of Nursing. The Director of Nursing stated, "Resident #75's left heel pressure ulcer is assessed and monitored under the care of PACE physician and staff." She said the ulcer should have been assessed within a week after the wound was first identified but a treatment should have been started immediately.

The resident's left heel pressure ulcer wound was

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being cared for by PACE, and assessed at the PACE clinic on a weekly basis and included the following:

1. 04/30/19 - Resident #75 was first identified with an unstageable to his left heel on 04/30/19 at approximately 10:35 a.m., at the nursing facility by LPN #1. However, on the same day at approximately 2:19 p.m., a skin assessment was completed at the PACE clinic. The assessment did not show evidence that the left heel unstageable pressure ulcer was present or assessed.

2. 05/02/19 - Under skin integrity/wound assessment for did not include documentation the left heel (unstageable) pressure ulcer was assessed (no documentation.)

3. There was no skin assessment completed for week of May 5, 2019 by PACE or the facility.

4. 05/14/19 - left heel with unstageable wound approximately 2 x 2 with redness around edges PACE (NP) to enter orders to cleanse with normal saline, apply *betadine and dry dressing daily.

5. 05/21/19 - Note: participant was seen today for weekly assessment. Participant skin remains intact at this time without skin breakdown. Will continue to follow weekly and report skin concerns to MD (missing last page.)

6. 05/28, 06/04, 06/11 and 6/18/19 - Participant was seen in the clinic today for wound care Cleanse the wound to the back of the left heel with normal saline, pat dry, and painted the area with betadine (no measurements documented.)

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7. 07/02/19 - Participant was seen in the clinic for wound care Eschar area noted to left heel is currently being followed by Podiatry; area measured approximately 2.5 cm x 2.5 cm, no odor or drainage noted. Applied allevyn to left heel as ordered (no measurements documented.)

8. 07/09/19 - Participant was seen in the clinic today for wound care to left heel. Cleansed with normal saline and covered with an allevyn dressing; area is dry and intact (no measurements documented.)

9. 07/16/19 - Participant was seen in the clinic today for wound care to left heel. Cleansed with normal saline and covered with an allevyn dressing; area is dry and intact (no measurements documented.)

10. 07/18/19 - Participant was seen in the clinic today for wound care. No dressing present. Area to left heel is dry with eschar present; wound is not open, wound cleansed with normal saline and covered with an allevyn dressing (no measurements documented.)

The Administrator and Director of Nursing and were informed of the finding during a briefing on 07/18/19 at approximately 2:20 p.m. The surveyor asked, "What preventative measures were put in place to prevent the left heel pressure ulcer from worsening once it was first identified on 04/30/19." The Administrator said there should be a preventative care plan in place. The surveyor presented Resident #75's care plan to the Administrator for review. The Administrator reviewed the care plan then stated, "This is a poorly written care plan; he does not have a preventative care plan in place." The surveyor

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informed the Administrator and DON that the podiatrist made a recommendation on 07/01/19 for the use of prevalon boot due to the left heel ulcer but the order was never transcribed. The DON said, "PACE should have received the podiatrist recommendations and they should have either approved or declined the recommendation." The surveyor asked, "What is the purpose of prevalon boots." The DON stated, "To give off load to the heels; the prevalon boots form as a cradle to keep the heels from touching the bed." On the same day at approximately 5:35 p.m., the DON presented a physician order sheet signed by the PACE physician that read: "Podiatry note from 07/01/19 reviewed; agree with order for prevalon boots to be worn on both feet. Boots to be worn at all times except for cleaning and care."

An interview was conducted with Director of Nursing (DON) on 07/18/19 at approximately 5:45 p.m. The surveyor stated, "Resident #75's pressure ulcer was first identified on 04/30/19 with a black scab measuring 2 cm x 2 cm but later clarified as an unstageable pressure ulcer to his left heel. After the review of the Resident #75's clinical record showed evidence that a treatment was not started until 05/14/19; 14 days later; it that acceptable." The DON stated, "No, absolutely not acceptable." The surveyor asked, "What stage should a pressure ulcer be first identified and what can happen if a wound treatment was not started or seen by a physician for evaluation for 14 days after first being identified, she replied, "At a stage 1 and worse case scenario; gangrene, amputation, shock, sepsis or death could occur, treatment should have been started right away."

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Definitions:

*Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (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 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/) .

*Allevyn Adhesive Hydrocellular Foam Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressings-home.html).

*Prevalon helps minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals. By off-loading the

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F 684	Continued From page 52 heel, it delivers total, continuous heel pressure relief (www.hdis.com/prevalon-boot-heel-protector.html). * Betadine swab stick helps reduce bacteria that can potentially cause skin infection (www.drugs.com). *Diabetes is a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F 688	1. The MD provided a clarification order	8/26/19

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F 688	Continued From page 53 documentation review, the facility staff failed to provide one resident, Resident #13, in the survey sample of 39 residents with an assistive device to help prevent further contractures and/or decline in range of motion of hands. The findings included: The facility staff failed to provide Resident #13 with physician ordered hand palm guards to maintain range of motion. Resident #13 was re-admitted to the facility on 04/11/19 with diagnoses that included, but not limited to, functional quadriplegia, Anoxic Brain injury, Severe flexion contractures of all joints,and failure to thrive in adult. A Quarterly Minimum Data Set (MDS) dated 7/3/19 assessed the resident in the area of Hearing, Speech and Vision as having no speech, not able to make self understood and not able to understand. This resident was assessed as being severely impaired in the area of Vision. This resident was unable to be assessed in the area of Cognitive Patterns. In the area of Activities of Daily Living this resident was assessed requiring total dependence and one person physical assist in the areas of dressing, toileting and personal hygiene. This resident was not able to be assessed in the areas of transfer, walking, and locomotion. In the area of Functional Limitation in Range of Motion this resident was assessed as being impaired on both sides of the upper and lower extremity. A Care Plan dated 07/03/19 included: palm guard to both hands.	F 688	for Resident #13 on 08/14/19 to confirm palm guards were to be in place every pm x 12 hrs. The palm guards were placed on Resident #13 at 9 pm on 08/14/19. 2. All residents requiring assistive devices for contracture management are at risk if they are not utilized as ordered. 3. 100% of nursing staffs will be inserviced on F688 requiring the prevention of contractures and the use of assistive devices to promote/maintain joint function 08/06/19-08/22/19. 4. The Clinical Managers, or designee, will audit all residents requiring assistive devices for contracture management weekly x 8 weeks to assure devices are available and in place. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 688	Continued From page 54 A Physician and Occupational Therapy order dated 4/11/19 indicated use for foam palm guard at all times. A palm guard is used as a barrier between the fingers and palmar skin to prevent injury to the palm from severe finger flexion; decreases the risk of skin irritation from involuntary motions. www.medline.com Resident #13 was observed on 07/18/19 with the Rehabilitation Director and the Unit Manager. Resident #13 was observed without palmar guard to hand. Resident #13's hands were contracted with finger nails embedded into hands (no open wounds were observed). The Rehabilitation Director was asked if resident should have palmar guards on. The Rehabilitation Director stated, "Yes he should have them on at all times except with bathing." A request was made for a facility policy on Assistive Devices. The facility did not provide the policy prior to the time of exit.	F 688		
F 697 SS=G	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 staff interviews, resident interview, and clinical record review, and in the course of a complaint investigation, the facility staff failed to	F 697	1. Resident #84 was discharged home on 08/27/18. No immediate correction is possible.	8/26/19

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F 697	Continued From page 55 provide pain management consistent with professional standards of practice for one (Resident #84) of 39 residents in the survey sample, resulting in harm. The resident was not assessed for pain from the time of admission until the following day during occupational therapy. There was no evidence that once pain was identified that it was treated timely. The findings include: Resident #84 was admitted to the facility 08/16/2018. Resident #84 left the facility, AMA (Against Medical Advice) on 08/27/2018. Diagnoses included but were not limited to, Left Distal Femur Fracture, Left Distal Radius Fracture and End Stage Renal Disease. Resident #84's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/23/2018 coded the resident with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #84 as requiring extensive assistance of 1 with bed mobility, transfer, dressing, toilet use and personal hygiene, and limited assistance of 1 with eating. Per documentation in the clinical record, the resident was scheduled to go to outpatient dialysis on Mondays, Wednesdays and Fridays (time undetermined). On 07/19/2019 Resident #84's closed record was reviewed and revealed the following: Resident #84's Hospital Discharge Summary was reviewed and revealed that the resident was discharged from the hospital on 08/16/2018 and prior to discharge the resident was administered Hydromorphone (Dilaudid) 6 mg (milligrams) oral	F 697	2. All residents experiencing pain are at risk if pain assessments are not completed and medications to relieve pain are not provided. 3. The OT involved was inserviced on 08/15/19 regarding steps to take in reporting pain to clinical staff for timely intervention. All new admissions since 07/19/19 have been assessed for pain relief and medication management. 100% of licensed nursing staffs will be inserviced on Sentara Life Care policy entitled Pain Management, and procedures entitled Automated Dispensing Devices (E-Med Stat) and Ordering Controlled Medications which includes an escalation process for medications not readily available 08/06/19-08/22/19. 4. The MDS nurses, or designee, will round on all new admissions daily x 8 weeks to assess levels of pain and effectiveness of their pain management regime. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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at 6:33 p.m. "Hydromorphone is used to relieve pain...Hydromorphone is in a class of medications called opiate (narcotic) analgesics..." Source (https://medlineplus.gov/druginfo/meds/a682013html).

Resident #84 was admitted to the facility on 08/16/2018 at 7:50 p.m. The resident's Admission Physician Orders were reviewed an revealed the following was ordered for pain:
Hydromorphone (Dilaudid) 2 mg. tablet (1 tab) oral As Needed Every Four Hours-chronic pain, starting 08/16/2018; Hydromorphone 2 mg. tablet (2 tab) oral As Needed Every Four Hours-chronic pain, starting 08/16/2018;
Dilaudid (Hydromorphone) 2 mg. tablet (1 tablet) oral Four Times Daily-chronic pain, starting 08/17/2018;
Tylenol 8 Hour 650 mg. tablet, extended release (1 tablet) tablet oral chronic pain-Three Times Daily starting 08/17/2018.

There was a care plan dated 8/18/18-8/27/18 however there was no plan of care for pain management.

There was no pain assessment documented upon admission or during the night. The first pain assessment revealed in the clinical record was during the Occupational Therapy evaluation dated 8/17/19 as follows:

Review of OT (Occupational Therapy) Evaluation and Plan of Treatment notes dated 08/17/2018 at 10:52 a.m., which revealed the following: "Behaviors: Patient behaviors: tearful due to pain." "Pain at Rest: Intensity = 10/10; Frequency/Duration = Constant; Location : left side: Pain Description/Type: ache." "Pain With

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Movement: Intensity = 10/10; Frequency/Duration = Constant; Location: left side; Pain Description/Type: ache." There was no documentation indicating what was done about the severe pain assessed by OT.

Review of the Clinical Note entry dated 08/17/2018 at 7:20 p.m., was documented in part, as post dialysis as follows: "Medicated x2 for pain to left lower extremities 8/10 with pain medication only giving relief." There was no indication of when the resident went to, or returned from the dialysis center.

Review of eMedStat (an electronic locked medication storage unit) transactions revealed Hydromorphone Tab 2 mg was dispensed on 08/17/2018 at 10:03 a.m. however, there was no documentation of administration on the Medication Administration Record or nurses notes;

Review of the Medication Administration Record revealed the following:
Hydromorphone 2 mg. tablet (2 tabs) As Needed Every Four Hours was administered on 08/17/2018 at 2:15 p.m. and was effective;
Hydromorphone 2 mg. tablet (1 tab) oral As Needed Every Four Hours was administered on 08/17/2018 at 6:50 p.m. and was effective;
Dilaudid 2 mg. tablet (1 tablet) oral Four Times Daily was documented as administered on 08/17/2018 at the evening dose;
Dilaudid 2 mg. tablet (1 tablet) oral Four Times Daily was documented as administered on 08/17/2018 at bedtime; Tylenol 8 Hour 650 mg. tablet, extended release (1 tablet) was administered at bedtime on 08/17/2018. There was no time included on the MAR to indicate what

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"evening" or "bedtime" was.

There was no documented evidence that Resident #84 received or was offered pain medication prior to above.

On 07/19/2019 at 11:30 a.m., a telephone interview was conducted with Pharmacy Technician and she stated that the pharmacy received the order for Dilaudid (Hydromorphone) on 08/17/2018 at 8:13 a.m., the orders were entered into their system at 8:30 a.m. and then the medication was packaged at 10:30 a.m. and the driver left the pharmacy at 11:00 a.m. to make deliveries. Dilaudid was in the eMedStat machine on 08/16/2018 but required a hard script for the Dilaudid to be released. (There are 4 eMedStat machines in the facility and each machine has 20 Dilaudid's.) The Pharmacy Technician stated that the resident came in from the hospital with a hard script for Dilaudid on 08/16/2018 for a quantity of 60 however, the pharmacy was not made aware until 08/17/2018. The Pharmacy Technician stated that the nurses can notify the Pharmacy at anytime if they need a medication that is not available to them. The Pharmacy Technician stated that four (4) Dilaudid's were made available in the eMedStat machine at the facility on 08/17/2018 at 8:30 a.m. after receiving the order and sent the remaining 56 tablets to the facility on 08/17/2018. The Pharmacy technician stated that the facility pulled 2 Dilaudid's from the eMedStat machine at 9:56 a.m. No documentation of administration was revealed on the Medication Administration Record.

On 07/19/2019 at 2:20 p.m., an interview was conducted with the Administrator and she was asked, "What are your expectations of the nurses

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F 697	Continued From page 59 when new residents are admitted and they have new medication orders?" The Administrator stated, "I expect the nurses to process the orders immediately and if they are unable to process then the order should be escalated to the pharmacist and if needed escalated to the Director of Nursing." On 07/19/2019 at 4:00 p.m., a telephone interview was conducted with the complainant and she was asked, "What time did you receive your first dose of pain medication after admission to the facility on 08/16/2018?" The complainant stated, " I did not get anything for pain until after I returned from Dialysis the next day. I went to Dialysis and my leg was hurting." The complainant was asked, "What was you pain intensity on a rate of 1-10 that morning?" The complainant stated, "My pain was a 10! I had even called my son that morning at 3:00 a.m. crying, my leg hurt." Complaint deficiency.	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 observation, staff interviews, medical record review, and facility document review the facility staff failed to ensure ongoing communication and coordination between the	F 698	1. Resident #237 was discharged on 08/03/19. No immediate correction is possible. 2. All residents are at risk if necessary	8/26/19

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(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 60 nursing home and the dialysis facility on 7/13/19 and 7/16/19 for 1 of 39 residents in the survey sample, Resident #237. The findings included: Resident #237 was admitted to the facility on 7/12/19 with diagnoses to include but not limited to, Chronic Kidney Disease and Dependence on Renal Dialysis. Resident #237 is a new admission and the comprehensive Admission Minimum Data Set Assessment and Comprehensive Care Plan has not yet been completed. The resident's baseline care plan was reviewed, however there was no mention of dialysis noted. Resident #237's Hospital Discharge Summary dated 7/12/19 was reviewed and is documented in part, as follows: Discharge Diagnoses: ESRD (end stage renal disease) on PD (peritoneal dialysis) now HD (hemo-dialysis). Resident #237's Treatment Administration Record was reviewed and is documented in part, as follows: Dialysis Three Times Weekly Starting 7/12/19. Order Date: 7/12/19 Notes Monday and Thursday at 9:30 A.M. then Tuesday, Thursdays and Saturdays. Resident was signed off by nursing as going to dialysis on 7/12/19 and 7/16/19. On 07/17/19 at 11:00 AM Unit Manager Registered Nurse (RN) #3 was asked for Resident #237's Dialysis Communication Log.	F 698	information is not communicated between the dialysis center and the nursing facility. 3. The Dialysis Communication tool was revised on 08/09/19. 100% of licensed nursing staffs will be inserviced on Sentara Life Care policy entitled Dialysis Guidelines of Care to include interchange of information necessary for the resident's care 08/06/19-08/22/19. 4. The Clinical Manager, or designee, will audit 100% of communication tools for all residents receiving dialysis weekly x 8 weeks to assure information is being communicated as necessary. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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On 07/17/19 at 2:25 PM Unit Manager RN#3 provided the surveyor with a folder for Resident #237 that included a face sheet and the dialysis patient registration and a Dialysis Post Treatment with a fax date of 7/17/19 which was today.

Unit Manager RN#3 was asked when Resident #237's Dialysis Communication Log was started. Unit Manager RN#3 stated, "We put it together today after you asked for it we did not have one together when he went out for dialysis on Monday." The Surveyor asked what is the facility/dialysis communication procedure for their residents. Unit Manager RN#3 stated, "We should have an ongoing communication log between us and the dialysis center. We should get a set of vital signs and a weight that are done prior to transport, and any medications specific to be given after the treatments are sent as well. The dialysis center sends us back the pre and post weights and vitals. They also send us documentation of any issues they may have occurred with the resident during treatment."

The facility policy titled "Dialysis-Guidelines of Care" revised 1/22/18 was reviewed and is documented in part, as follows:

Policy Statement: The facility will provide patients and residents who require dialysis services that are consistent with professional standards of practice.

When a resident requires dialysis service, the resident must leave the facility to obtain dialysis. The facility will have an agreement or arrangement with an outside entity providing dialysis services.

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F 698	Continued From page 62 This agreement will address at least: *Development and implementation of the resident's care plan. *Interchange of information necessary for the resident's care. On 7/18/19 at approximately 4:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.	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.	F 755		8/19/19

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F 755	Continued From page 63 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in 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 staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure medications were provided per physician orders for 1 resident (Resident #84) of 39 residents in the survey sample. The findings include: Resident #84 was admitted to the facility 08/16/2018. Resident #84 left the facility, AMA (Against Medical Advice), on 08/27/2018. Diagnosis included but were not limited to, Left Distal Femur Fracture, Left Distal Radius Fracture and End Stage Renal Disease. Resident #84's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/23/2018 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. On 07/19/2019 Resident #84's Physician Order's were reviewed and revealed the following medications were ordered on 08/16/2018: Linzess 290 mcg (micrograms) capsule (1 cap) Capsule Oral Two Times Daily Starting 08/17/2018 and Prasugrel 10 mg (milligrams) tablet (1 tab) Tablet Oral One Time Daily Starting 08/17/2018. The brand name for Prasugrel is	F 755	1. Resident #84 was discharged home on 04/17/19. No immediate correction is possible. 2. All residents are at risk if prescribed medications are not available for administration as ordered. 3. 100% of all licensed nursing staffs will be inserviced on Sentara Life Care policy entitled Medication Administration to include physician and pharmacy notification for omitted doses or need for doses to be provided for administration and an After Hours Job Aid which includes ordering medications after hours from Sentara Rx 08/06/19-08/16/19. 4. The Clinical Managers will audit 5 charts weekly x 8 weeks to determine that new medication orders have been obtained timely and administered as ordered. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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F 755	Continued From page 64 Effient and is used to help prevent blood clots. Linzess is a prescription medication used in adults to treat irritable bowel syndrome with constipation (IBS-C) and chronic idiopathic constipation (CIC)-www.linzess.com. On 07/19/2019 at 11:30 a.m. the surveyor spoke to the Pharmacy Technician by phone and she said that Linzess and Effient were high cost medications and needed approval to interchange. Medications that cost over $300.00 have to be approved by the facility and they had tried to get the facility to approve. The Pharmacy Technician said Linzess was made available to the resident and sent on 08/22/2018. The pharmacy sent a 15 day supply, 30 tablets, of the Linzess, which cost $447.00. The Pharmacy Technician stated that Effient cost $483.00 for 30 tablets. The Effient was not sent. Review of the Medication Administration Record revealed that Resident #84 was administered Linzess and Prasugrel starting on 08/17/2018. It was determined that Resident #84 provided the medication from home. An interview was conducted with the Administrator on 07/19/2019 at approximately 2:00 p.m. and she was asked, "What is your practice when accepting residents that have high cost medications?" The Administrator stated, "My response to the pharmacy is "Please send." The Administrator was asked, "Should someone from the facility have responded to the pharmacy?" The Administrator stated, "Yes." Complaint deficiency.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/19/19

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F 761	Continued From page 65 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview of 8 medication carts and 5 medication rooms, the facility staff failed to dispose of expired medications, biologicals and nutritional supplements; and failed to secure a medication cart. The findings include: 1. The facility staff failed to dispose of one Nutritional drink pack. (Prostat) located in the medication cart on unit 300 (Town side).	F 761	1. One pack of ProStat nutritional powder, one bottle of unopened Humalin insulin, and one pack of expired urine culture kits were discarded immediately. One medication cart was unlocked when not in direct observation by staff. The cart was locked immediately. 2. All residents receiving medications or requiring a urine culture are at risk if products are not used within the "use by" date. 3. 100% of licensed nursing staffs will be	

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F 761	Continued From page 66 2. The facility staff failed to discard one unopened bottle of Humulin Insulin located in the refrigerator of the medication room medication on Coastal Unit 400. 3. The facility staff failed to discard an expired bag of multiple urine culture and sensitivity containers/kits. 4. The facility staff failed to lock the medication cart when unattended on the Garden Spring Unit 100. On 07/17/19 at approximately 11:25 AM an inspection of the medication cart was conducted on the Town and Country unit. The cart was located on the "Town" side of the unit. A packet of Prostat sugar free vanilla liquid protein with an expiration date of 02/21/19 was observed in the cart. LPN #4 (Licensed Practical Nurse) was asked what should have been done with the expired protein pack? She said that the expired Prostat should have been discarded. On 07/17/19 at approximately 12:28 PM an inspection of the Coastal Unit 400 Medication Room was conducted and revealed an unopened bottle of Humulin R insulin 100 unit/ml (milliliter) with an expiration date of 04/2019. Licensed Practical Nurse (LPN) #6 was asked what should have been done? She stated "Typically pharmacy should have pulled the expired medicine." On 07/17/19 at approximately 3:40 PM an inspection was conducted in the the Medication room located on the Great Bridge Pavilion Unit 300. During the inspection an expired bag of urine culture and sensitivity containers/kits were located in the cabinet were found. They had an	F 761	inserviced on Sentara Life Care policy entitled Storage of Medications to include removal of outdated medications or products from stock 08/06/19-08/16/19. 4. The Staff Development Coordinator (SDC), or designee, will check each medication storage area weekly x 8 weeks to assure all outdated medications or products have been removed per policy. The SDC will also audit 4 medications carts weekly x 8 weeks to assure they remain locked when not in direct observation by a licensed nurse. All audits will be forwarded to the DON, summarized, and presented to the QAPI committee for recommendations and additional oversight.	

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F 761	Continued From page 67	F 761		

expiration date of 03/2019. (RN) Registered Nurse #2 was asked what should have been done with the expired kits? He stated "It should have been dispose of."

On 07/17/19 at approximately 4:20 PM, during a medication pass observation. Licensed Practical Nurse #3 left her cart unattended and unlocked with the keys inserted inside of the lock for approximately, 4 minutes. She stated that she was "going over to another unit to borrow a glucometer." She was asked by the surveyor what should should have been done when walking away from your medication cart? She stated "I should have locked it and taken the keys with me."

Policy: Storage of Medications. Revision Date: 02/15/2018. Policy statement: Medications, treatments, and biological's are stored safely, securely, and properly following manufacturer's recommendations or facility policy. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exist.

On 07/18/19 at approximately 4:12 PM, a pre-exit interview was conducted with the Administrator and the Director of Nursing (DON). They were debriefed on the above concerns. The DON stated "In addition to the Pharmacy Review, it is the nurse's responsibility to discard expired

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F 761	Continued From page 68 medications."	F 761		
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 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	F 880		8/26/19

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F 880	Continued From page 69 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 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 observation, staff interview, and facility documentation review, the facility staff failed to follow hand hygiene practices consistent with accepted standards of practice while performing wound care for 1 of 39 residents in the survey sample, Resident #6. The findings include:	F 880	1. LPN #6 did not wash her hands before applying new gloves. She also failed to clean a bedside table top after using it to hold supplies for wound care and did not clean her pen after using it to label the dressing. No immediate correction is possible, however, the table top was disinfected on 07/19/19 when noted and	

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F 880	Continued From page 70 Resident #6 was admitted to the facility on 07/27/2018. Diagnosis included but were not limited to, Quadriplegia and Neurogenic Bladder. Resident #6's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/02/2019 coded Resident #6 with a BIMS (Brief Interview for Mental Status) score of 15 which indicates no cognitive impairment. On 07/18/2019 at 1:06 p.m., the surveyor observed Licensed Practical Nurse (LPN) #6 provide wound care to Resident #6's right gluteal fold wound. LPN #6 washed her hands with soap and water and then proceeded to Resident #6's bedside to begin wound care. LPN #6 stated that she had already been in Resident #6's room and cleaned his overbed table with a germicidal cleaner and placed his wound care supplies on the table. LPN #6 donned clean gloves and removed the resident's soiled dressing from the right gluteal fold. LPN #6 removed the dirty gloves and donned clean gloves without performing hand hygiene between changing of gloves. LPN #6 cleaned the wound with dermal wound cleanser and dried the wound area with a gauze dressing. LPN #6 cut a piece of Xeroform gauze and placed it on the wound and covered it with a 2 X 2 gauze dressing and then covered the gauze dressing with roll stretch. LPN #6 failed to apply clean gloves prior to cutting and handling the Xeroform, placing it on the wound with the gloves used to clean the wound. LPN #6 removed a Sharpie marker hanging on her name badge, removed the cap and wrote the date and her initials on the dressing, replaced the cap on the marker. LPN #6 removed her soiled gloves. LPN #6 failed to clean the Sharpie marker after handling it with her dirty gloves. LPN #6 gathered	F 880	the pen was discarded. Resident #6 was most recently reviewed by the physician wound care specialist on 08/12/19. His wound continues to improve in size without slough and with 100% granulation tissue present. The Clinical Manager verified by direct observation of LPN #6 that Resident #6 is receiving proper infection control measures during wound care on 08/09/19. 2. All residents are at risk if staff fail to wash hands when changing gloves and if table surfaces or other objects are not disinfected after use. 3. LPN #6 received 1:1 training by the Administrator regarding hand hygiene, surface and other object cleaning on 08/09/19. 100% of facility staffs will be inserviced on Sentara Life Care procedure entitled Handwashing/Hand Hygiene to include washing hands after glove removal even when donning new gloves as well as surface and other object cleaning after procedures 08/06/19-08/22/19. 4. The Clinical Managers, or designee, will observe wound care on 2 residents weekly X 8 weeks to assess staff compliance with handwashing, glove changing, and surface and other object cleaning. All audits will be forwarded to the DON, summarized and presented to the QAPI committee for recommendations and additional oversight.	

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the left over supplies and placed them in Resident #6's cubby cabinets. LPN #6 then went into the bathroom and washed her hands with soap and water. LPN #6 failed to clean Resident #6's overbed table with a decontaminate after performing wound care.

On 07/18/2019 at approximately 4:00 p.m., the surveyor reviewed wound care observations with LPN #6. LPN #6 was asked, "Did you sanitize or wash your hands between changing of your gloves?" LPN #6 stated, "No, I did not want to leave the resident's bedside to wash my hands." LPN #6 stated, "I should have removed my dirty gloves and cleansed my hands when going from dirty to clean." LPN #6 was asked, "Did you clean the overbed table after completing wound care?" LPN #6 stated, "No, I should have cleaned the table. I usually clean it with the sani wipes."

An interview was conducted with the Administrator and Registered Nurse (RN) #4 on 07/18/2019 at 4:15 p.m. and they were asked, "What are your expectations of nurses when performing wound care and going from dirty to clean in a procedure and changing of gloves?" RN #4 stated, "I expect the nurses to sanitize, wash their hands in between changing their gloves and going from dirty to clean procedures." RN #4 was asked, "What are your expectations of the nurse when they have completed wound care treatments?" RN #4 stated, "I expect the nurse to clean the surface of the table with sani wipes and remove the trash."

On 07/19/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator and Director of Nursing was informed of the findings. The facility did not present any further information about the

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	495215	A. BUILDING _____ B. WING _____	C 07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 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 72 finding.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain an effective antibiotic stewardship program. The findings include: Review of the facility "Infection Control Log," from January 2019 until June 2019 revealed the following: On multiple occasions from January of 2019 through June 2019, there was no documentation (left blank) under the column, "culture/test obtained Y/N (yes/no)," to determine if a test or culture was collected for those residents diagnosed with an infection. On multiple occasions, there was also no documentation under column titled "culture," to identify the organism causing the infection. On 7/16/19 at 3:11 p.m., an interview was conducted with the infection control nurse (other staff member) #5. When asked the process for tracking and trending infections, OSM # 5 stated	F 881	1. Multiple occasions were noted on the facility Infection Control Log January-June 2019 where culture results were not recorded. The Infection Control Log for January-June 2019 was reviewed for all current residents with missing information. All results have been recorded as indicated. The Infection Control Log is current through 08/19/19. 2. All residents are at risk if antibiotics are prescribed when not necessary. 3. The Infection Control Log was reviewed with the Infection Prevention Nurse on 08/08/19 to determine ways to clearly identify when cultures were obtained elsewhere and the results of those cultures. The Infection Prevention Nurse was also updated on 08/08/19 to address the review of laboratory findings and what steps to take if a culture was not ordered by the provider. 4. The Infection Prevention Nurse will audit use of antibiotics twice weekly x 8	8/26/19

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F 881	Continued From page 73 that she tracks infections using a computer program called Vision. OSM #5 stated that she obtains her information from residents charts and documents the following on the infection control log: If the infections were acquired at the facility or present upon admission or re-admission, any cultures/tests obtained, the culture results if indicated, the antibiotic used for treatment and the resolve date of the infection. When asked why there were so many blanks (no documentation) under column "culture/test obtained," and "culture," OSM #5 stated that most of the columns were blank because when residents were admitted or re-admitted to the facility with infections, she did not have access to any cultures or tests that were obtained in the hospital. When asked if the history and physical and d/c (discharge) summary from the hospital were sent with residents upon admission to facility, OSM #5 stated that at times, the hospital paperwork did not contain that information. When asked if she could call the hospital to obtain that information, OSM#5 stated, "I guess we could, yes." When asked why it was important for document if a culture was obtained and the organism causing the infection if a culture/test was obtained; OSM #5 stated that it was important to document that information to ensure the resident was on the appropriate antibiotic. On 7/17/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concern. Facility policy titled, "Infection Prevention and Control Program," documents in part the following: "Surveillance: A. The facility tracks infections among residents upon admission and	F 881	weeks to monitor for appropriate antibiotic usage. Infection Control Logs will be reviewed weekly by the DON to assure adequate documentation regarding culture results. All audits will be summarized by the DON, and presented to the QAPI committee for recommendations and additional oversight.	

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F 881	Continued From page 74 throughout their stay; collecting information necessary for evaluation to determine whether present upon admission or health care associated, analyzing and reporting monthly and quarterly to QAPI as required...C. The facility remains alert for potential outbreaks by the following methods: 1. Daily, weekly and monthly review and analysis of surveillance data, looking for any increase in particular types of infections and any clustering patterns. 2. Review lab findings for the isolation of uncommon or unusual organisms such as opportunistic pathogens and communicable disease agents."	F 881		