STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 8/14/19 through 8/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid/Medicare standard survey was conducted 08/14/19 through 08/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 29 current residents reviews and 6 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed for 1 of 35 residents in the survey sample, to ensure that the assessment accurately reflected Resident #22's status. The findings included:	F 641	F641 1. Resident #22 MDS was modified 8/15/2019. 2. Review of MDSs coded with side rails conducted to determine accuracy of coding of side rails. 3. MDS Coordinator was re-educated to Section P and coding side rails. 4. MDSs completed will be reviewed by MDS Coordinator for accuracy of coding side rails weekly for 4 weeks. 5. Audits will be reviewed during the monthly/quarterly QAPI meetings. 9/16/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jemille Taylor — TITLE: Administrator — (X6) DATE: 8/30/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 641	Continued From page 1 Resident #22 was admitted to the facility on 04/11/2019. Diagnosis included but were not limited to, Cognitive Communication Deficit and Type 2 Diabetes Mellitus. Resident #22's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 06/10/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #22 as requiring extensive assistance of 1 with dressing and personal hygiene and extensive assistance of 2 with bed mobility, transfer and toilet use. On 08/15/2019 review of Resident #22's Quarterly MDS, Section "P"- Restraints, revealed that the resident was coded as using Bed Rails less than daily. On 08/15/2019 Resident #22's Physician Order Summary was reviewed and failed to evidence that the resident had orders for Bed Rails. Resident #22's Comprehensive Care Plan was reviewed and failed to evidence that the resident had a care plan for Bed Rails. On 08/15/2019 at approximately 4:00 p.m., Resident #22 was asked, "Do you use Bed Rails?" Resident #22 stated, "No." On 08/15/2019 at approximately 5:00 p.m. a copy of Resident #22's Quarterly MDS for 06/10/2019 and the Comprehensive Care Plan was requested. On 08/16/2019 at approximately 10:00 a.m. a modified copy of the Quarterly MDS for	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 641	Continued From page 2	F 641		

06/10/2019 attached to a "CMS (Centers for Medicare & Medicaid Services) Submission Report" for modification with a submission date of 08/15/2019 at 6:29 p.m. and a processing completion date of 08/15/2019 at 6:33 p.m. was received.

An interview was conducted with the Director of Nursing (DON) on 08/16/2019 at approximately 10:30 a.m. and she was asked, "Can you explain the submission report to CMS?" The DON stated, "Resident #22 has never used Bed Rails. There was an error in coding on the MDS."

On 08/16/2019 at approximately 11:10 a.m., an interview was conducted with the MDS Coordinator and she was asked, "Did Resident #22 use bed rails, less than daily, as coded on the Quarterly MDS dated 06/10/2019?" The MDS Coordinator stated, "No, (residents name) never used bed rails. That was an error in coding. Sometimes I enter information too fast. From now on I am going to make a point to go back and check to make sure before I lock and sign the MDS that it is correct." The MDS Coordinator was asked, "When did you identify that you incorrectly coded the MDS for bed rails?" The MDS Coordinator stated, "After you requested information."

On 08/16/2019 a copy of the facility policy on MDS Assessments was requested. The facility provided a copy of "Centers for Medicare & Medicaid Services' Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual MDS 3.0 User's Manual Version 1.16" updated October 2018.

On 08/16/2019 at approximately 6:30 p.m., at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 641	Continued From page 3 pre-exit meeting the Administrator and the Director of Nursing was informed of the finding. The facility did not present any further information about the finding.	F 641	F656	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	1. Resident #154 Foley Catheter was secured. Staff verified Resident #10 Keppra and Carbidopia-levodopa was available and being given as ordered by physician. 2. Resident with Foley catheters residing in facility are at risk. Resident receiving Keppra and Carbidopa-levodopa in facility are at risk. 3. Licensed staff were re-educated on policy and procedure of medication availability, administration per physician order, and to ensure catheters are secured. 4. A Foley catheter audit will be completed 3 x a week x 2 months by D.O.N/Designee to ensure catheters are secured. An audit of resident receiving Keppra and Carbidopa-levodopa will be completed 3 x a week x 2 months by D.O.N/Designee to ensure Keppra is administered. 5. Audits will be reviewed in monthly and quarterly QAPI Meetings. 9/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4	F 656		

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 observation, staff interview, clinical record review and facility document review the facility staff failed to implement an approach listed in the residents Comprehensive Person-Centered Plan of Care for 2 of 35 residents in the survey sample (Resident # 154 & #10). The facility failed to implement an indwelling catheter securement device for Resident #154 and failed to administer medications for seizure disorder and Parkinson's Disease for Resident #10.

The findings include:

1. Resident #154 was admitted to the facility on 7/15/19 with an indwelling Foley catheter for diagnoses of BPH (benign prostatic hyperplasia-an enlarged prostate gland that can cause urination difficulty) and UTI (urinary tract infection). The current MDS (Minimum Data Set) an admission with an assessment reference date of 7/22/19 coded the resident as having long and short term memory deficits and severely impaired daily decision making skills. The resident was coded as having an indwelling catheter (a plastic tube inserted into the bladder to drain urine).

The Comprehensive Person-Centered Plan of Care dated 7/16/19 identified that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5	F 656		

had a potential for Urinary Tract Infection due to the presence of an indwelling catheter. The goal was the resident's risk for UTI will be minimized through the next review. One of the interventions listed to achieve the goal was to secure the catheter and tubing appropriately.

On 8/15/19 at 1:08 p.m., the resident was observed lying in bed, the Foley catheter bag was observed making contact with the floor mat. Registered Nurse #1 was asked to show the surveyor Resident #154's Foley catheter securement device (anchor). The RN palpated for the securing device through the resident's sweat pants and could not feel one. He lowered the resident's pants and observed that there was no securement device. The RN then went and obtained an anchor and secured the catheter. Further assessment of the catheter tubing entrance evidenced the resident had an elongated cleaved non open area. The bed was lowered after application of the anchor and the drainage bag was left making contact with the floor mat. A request for the facility's indwelling catheter management policy was made at this time.

The nurse practitioners note dated 8/15/19 read, in part as follows:...(resident description) being seen per staff request in regards to urethral erosion. Due to an indwelling Foley catheter. Upon assessment there was a well healed site from a previous catheter related wound...

The facility did not have a policy or procedure on the management of an indwelling catheter. A copy of Lippincott Nursing Procedures eighth edition was provided to this surveyor by the Infection Control Nurse on 8/16/19 at 4:46 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6	F 656		

who stated, "We use this for our policy." Page 392 read, in part: Secure the catheter using a catheter securement device. If a securement device is not available, tape the catheter to the patient's abdomen or thigh to prevent pressure on the urethra.

The above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting on 8/16/19.

2. Resident #10 was admitted to the facility on 11/2/2013 with diagnoses of Alzheimer's Disease, muscle weakness, Parkinson's Disease, Convulsions, shortness of breath and dysphagia. A review of the clinical records indicated Resident #10 was not provided physician ordered Keppra (a medication used for the treatment of seizure disorder) and Carbidopa-Levodopa (a medication used for the treatment of Parkinson's Disease symptoms).

A Quarterly Minimum Data Set (MDS) dated 05/29/19 assessed this resident as having unclear speech and not able to make herself understood. This resident rarely understood and rarely understood others. This resident's vision was highly impaired. In the area of Activities of Daily Living this resident was assessed as requiring extensive assistance in the area of transfer, dressing, eating, toilet use and required two person physical assist. Resident #10 was coded in the area of Neurological as having Seizure disorder or Epilepsy.

A review of Resident #10's Care Plan dated 6/10/19 indicated Resident #10 was at risk for falls due to poor sense of safety awareness related to diagnoses of Alzheimer's disease and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 diagnose of Seizures. Goal- Risk for falls will be minimized through next review. Interventions- Administer medication as ordered and monitor for sedation. A review of the clinical record dated 2/3/19 included: "Resident did not receive scheduled Keppra MD aware. A review of the Medication Administration Record (MAR) dated February 2019 indicated: Keppra Solution 500 MG/5 ML, give 5 ml via G-tube every 12 hours for seizures. The MAR indicated Keppra was to be administered at 0900 and 2100 (9 PM). The 9:00 AM hour for February 3 was noted with a (7) which indicated other see nurses note." Further review of the clinical records indicated that physician order Carbidopa-Labodopa tablet 10-100 mg give one tablet via Peg Tube every 8 hours related to Parkinson Disease was not administered during the 6 AM hour as ordered by the physician on February 19, 2019. During an interview on 08/15/19 at 3:15 PM with the Director of Nursing (DON) she was asked was the medication available for Resident #10 and if Resident #10 received the medication. The DON stated, Resident #10 did not received the ordered medication nor were the medication available. A facility Medication Administration policy and procedure indicated: Policy- "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 Medication Administration: 1. Medications are administered in accordance with writer orders of the Prescriber. " No further information was provided by the facility staff.	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 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	F 657	**F657** 1. Resident #30 care plan was modified on 8/16/2019. Resident # 39 care plan was modified on 8/16/2019. 2. Review of care plans with prophylactic treatment of UTI and Foley catheters was completed. 3. MDS Coordinator re-educated on comprehensive care plans with emphasis on reviewing physician orders. Licensed staff were re-educated on policy and procedure of revision of care plans. 4. Care plans for residents on prophylactic treatment of UTI and Foley Catheter will be reviewed with subsequent MDS completion weekly for 3 months. 5. Audits will be reviewed in monthly and quarterly QAPI Meetings 9/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9	F 657		

by:
Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise two of 35 residents (Resident #30 and #39) comprehensive person-centered care plans in the survey sample.

The findings included:

1. The facility staff failed to revise Resident #30's comprehensive person-centered care plan to include the use of an indwelling Foley catheter. Resident #30 was originally admitted to the facility on 05/17/19. Current diagnosis included but not limited to pressure ulcer of sacral region, stage IV.

Resident #30's Minimum Data Set (MDS-an assessment protocol), a significant change MDS with an Assessment Reference Date of 06/21/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #30 as total dependence of two with bathing, extensive assistance of two with bed mobility, transfer, dressing, toilet use and personal hygiene for Activities of Daily Living (ADL). The MDS also coded the resident for being always incontinent of bladder and frequently incontinent of bowel.

During the initial tour on 08/14/19 at approximately 2:38 p.m., an indwelling *Foley catheter was observed to bedside drainage.

The physician Order Sheet (POS) for August 2019 included the following orders:
-06/24/19-Insert Foley catheter for wound healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 Resident #30's comprehensive person-centered care plan did not include the use of an indwelling Foley catheter. An interview was conducted with the Director of Nursing (DON) on 08/16/19 at approximately 3:50 p.m. When asked "Who is responsible for updating/revision of the resident's person-centered care plans, she replied, "The nurses, Unit Manager (UM), MDS Coordinator as well as myself is responsible to updating/revising care plans." When asked, "Should the use of Resident #30's Foley catheter be care planned," she replied, "Absolutely." On 08/16/19 at approximately 5:05 p.m., the following care plan was provided to the surveyor with a revision date of 08/16/19: -Focus: Alteration in elimination of bladder (Indwelling Urinary Catheter). -Goal: will no have complications from use of my indwelling catheter such as pain, infection or obstructions. -Intervention to manage goals include but not limited to anchor catheter, avoid excessive tugging on the catheter during transfer and delivery care, check catheter tubing for proper drainage and position, irrigate catheter as ordered and keep drainage bag of catheter below the level of the bladder at all times and off the floor. The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 08/16/19 at approximately 6:15 p.m. The facility did not present any further information about the findings.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 Definitions: -Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html). 2. The facility staff failed to revise Resident #39's comprehensive person-centered care plan to include the history of Urinary Tract Infections (UTI's) who is receiving a scheduled antibiotic, *Doxycycline 100 milligrams, daily for prophylaxis. Resident #39's Minimum Data Set (MDS), a quarterly with an Assessment Reference Date (ARD) of 07/05/19 coded Resident #39 Brief Interview for Mental Status (BIMS) score of 11 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #39 with total dependence of two with toilet use and transfer, total dependence of one with bathing, extensive assistance of one with bed mobility, dressing and personal hygiene for Activities of Daily Living care. The MDS also coded the resident for being frequently incontinent of bladder and always incontinent of bowel. Resident #39's comprehensive person-centered care plan did not include the history of UTI's, who is receiving an antibiotic (Doxycycline 100 mg) daily prophylactically. An interview was conducted with the Director of Nursing (DON) on 08/16/19 at approximately 9:43 a.m. When asked "Who is responsible for updating/revision of the resident's person-centered care plans," she replied, "The nurse, Unit Manager (UM), MDS Coordinator as	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 well as myself is responsible to updating/revising care plans." On 08/16/19 at approximately 10:17 a.m., an interview was conducted with the MDS Coordinator. The surveyor asked, "Should Resident #39's person-centered care plan include the use of a scheduled antibiotic (Doxycycline 100 mg) daily for (UTI) prophylaxis?" The MDS Coordinator reviewed Resident #39's physician orders and the person-centered care plan. After the review, she stated, "I do not see it on the care plan." She said the UTI should be care planned because Resident #39 is receiving scheduled antibiotics; there should be a specific care plan for the use of her antibiotic. The MDS Coordinator said "I do not know how I overlooked, I just did not capture it, it just was not care planned." On 08/16/19 at approximately 10:30 a.m., the following care plan was provided to the surveyor with a revision date of 08/16/19: -Focus: Resident #39 has history of Urinary Tract Infections (UTI) - potential or actual due to history chronic urinary tract infection. -Goal: At risk for UTI's will be minimized through next review (10/08/19). -Interventions: Administer antibiotics as ordered and observe and report signs and symptoms of UTI. The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 08/16/19 at approximately 6:15 p.m. The facility did not present any further information about the findings. Definition:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 13 -Doxycycline is used to treat bacterial infections; it works by preventing the growth and spread of bacteria (https://medlineplus.gov/druginfo/meds/a682514.html).	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 record review and staff interview, the facility staff failed to provide one resident (Resident #10) in the survey sample of 35 residents, with physician ordered medications. The findings included: Resident #10 was admitted to the facility on 11/2/2013 with diagnoses of Alzheimer's Disease, muscle weakness, Parkinson's Disease, Convulsions, shortness of breath and dysphagia. A review of the clinical records indicated Resident #10 was not provided physician ordered Keppra (a medication used for the treatment of seizure disorder) and Carbidopa-Levodopa (a medication used for the treatment of Parkinson's Disease symptoms). A Quarterly Minimum Data Set (MDS) dated 05/29/19 assessed this resident as having unclear speech and not able to make herself understood. This resident rarely understood and rarely understood others. This resident's vision	F 658	**F658** 1. **Staff verified Resident #10 Keppra and Carbidopa-Levodopa was available and being given as ordered by physician.** 2. **Residents receiving Keppra and Carbidopa-Levodopa in facility are at risk.** 3. **Licensed staff were re-educated on policy and procedure of medication availability and administration per physician order.** 4. **An audit of resident receiving Keppra and Carbidopa-levodopa will be completed 3 x a week x2 months by D.O.N/Designee to ensure Keppra and Carbidopa-levodopa is available and being given per physician order.** 5. **Audits will be reviewed in monthly and quarterly QAPI Meetings** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14	F 658		

was highly impaired. In the area of Activities of Daily Living this resident was assessed as requiring extensive assistance in the area of transfer, dressing, eating, toilet use and required two person physical assist. Resident #10 was coded in the area of Neurological as having Seizure disorder or Epilepsy.

A review of Resident #10's Care Plan dated 6/10/19 indicated Resident #10 was at risk for falls due to poor sense of safety awareness related to diagnoses of Alzheimer's disease and diagnose of Seizures. Goal- Risk for falls will be minimized through next review. Interventions- Administer medication as ordered and monitor for sedation.

A review of the clinical record dated 2/3/19 included: "Resident did not receive scheduled Keppra MD aware. A review of the Medication Administration Record (MAR) dated February 2019 indicated: Keppra Solution 500 MG/5 ML, give 5 ml via G-tube every 12 hours for seizures. The MAR indicated Keppra was to be administered at 0900 and 2100 (9 PM). The 9:00 AM hour for February 3 was noted with a (7) which indicated other see nurses note."

Further review of the clinical records indicated that physician order Carbidopa-Labodopa tablet 10-100 mg give one tablet via Peg Tube every 8 hours related to Parkinson Disease was not administered during the 6 AM hour as ordered by the physician on February 19, 2019.

During an interview on 08/15/19 at 3:15 PM with the Director of Nursing (DON) she was asked was the medication available for Resident #10 and if Resident #10 received the medication. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 DON stated, Resident #10 did not received the ordered medication nor were the medication available. A facility Medication Administration policy and procedure indicated: Policy- "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medication Administration: 1. Medications are administered in accordance with writer orders of the Prescriber. " No further information was provided by the facility staff.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690	**F690** **1. Resident #154 Foley catheter was secured and drainage bag was removed off of floor.** **2. Residents with Foley catheters residing in facility are at risk.** **3. Nursing staff were re-educated by the D.O.N/Designee on the professional standards care of Foley catheter.** **4. A Foley Catheter audit will be completed x3 a week x 2 months by D.O.N./Designee to ensure catheters are secured. Audits will be completed during care keeper rounds x5 a week observing for misplacement of tubing and Foley bags on the floor.** **5. Audits will be reviewed in monthly and quarterly QAPI Meetings.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 16 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 35 residents in the survey sample received appropriate care and services to prevent complications from an indwelling Foley catheter, Resident # 154. The findings include: Resident #154 was admitted to the facility on 7/15/19 with an indwelling Foley catheter for diagnoses of BPH (benign prostatic hyperplasia-an enlarged prostate gland that can cause urination difficulty) and UTI (urinary tract infection). The current MDS (Minimum Data Set) an admission with an assessment reference date of 7/22/19 coded the resident as having both long and short term memory deficits and severely impaired daily decision making skills. The	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 17	F 690		

resident was coded as having an indwelling catheter (a plastic tube inserted into the bladder to drain urine).

The Comprehensive Person-Centered Plan of Care dated 7/16/19 identified that the resident had a potential for Urinary Tract Infection due to the presence of an indwelling catheter. The goal was the resident's risk for UTI will be minimized through the next review. Two of the interventions listed to achieve the goal was to provide indwelling catheter care every shift and as needed, and secure catheter and tubing appropriately.

The physician order dated 7/15/19 was to administer Cipro (an antibiotic) 500 milligrams one tab twice a day for 14 days for the treatment of a UTI.

On 8/14/19 on initial tour at approximately 11:45 a.m., the resident was observed in bed with a towel over his head. The bed was in the lowest position, the catheter tubing and drainage bag were making contact with the fall mat on the floor.

On 08/15/19 10:56 a.m., the resident was in the low bed, the catheter drainage bag was observed making contact with the floor.

On 08/15/19 at 1:08 p.m., the resident was lying in bed, the Foley catheter bag was observed making contact with the floor mat. Registered Nurse #1 was asked to show the surveyor Resident #154's Foley catheter securement (anchor) device. The RN palpated for the securing device through the resident's sweat pants and could not feel one. He lowered the resident's pants and observed that there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 18	F 690		

securement device. The RN then went and obtained an anchor and secured the catheter. Further assessment of the catheter tubing entrance evidenced the resident had an elongated cleaved non open area. The bed was lowered after application of the anchor and the drainage bag was left making contact with the floor mat. A request for the facility's indwelling catheter management policy was made at this time.

The nurse practitioners note dated 8/15/19 read, in part as follows:...(resident description) being seen per staff request in regards to urethral erosion. Due to an indwelling Foley catheter. Upon assessment there was a well healed site from a previous catheter related wound...

On 08/16/19 9:53 a.m., observed the resident in bed, the bed was in the low position with the Foley drainage bag making contact on the floor. The unit manager was then asked to escort this surveyor into the room. The drainage bag position was pointed out to the unit manager. She stated the bag is on the floor, when asked why the bag should not be on the floor she stated, "Infection Control." A second request for the facility's policy on indwelling catheter management was made.

The facility did not have a policy or procedure on the management of an Indwelling Catheter. A copy of Lippincott Nursing Procedures eighth edition was provided to this surveyor by the Infection Control Nurse on 8/16/19 at 4:46 p.m., who stated, "We use this for our policy." Page 392 read, in part: Secure the catheter using a catheter securement device. If a securement device is not available, tape the catheter to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 19 patient's abdomen or thigh to prevent pressure on the urethra...Don't place the drainage bag on the floor. The above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting on 8/16/19.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview the facility staff failed to ensure 1 of 35 residents in the survey sample respiratory care equipment was maintained in a manner to ensure optimal functioning, Resident #49. The fixtures on both sides of the oxygen concentrator cabinet that hold the external air filters in place were missing. The findings include: Resident #49 had a re-admission date of 7/3/19 with diagnoses to include, but not limited to: chronic respiratory failure, sleep apnea and chronic obstructive pulmonary disease (COPD). The resident was coded as scoring a 15 out of a possible 15 on the Brief Interview for Mental	F 695	**F695** 1. **Resident #49 oxygen concentrator was replaced.** 2. **Resident with oxygen concentrator residing in facility are at risk.** 3. **Staff were re-educated on the care of oxygen concentrators.** 4. **Audits will be completed during care keeper rounds 5x a week x2 months to ensure placement of external filters.** 5. **Audits will be reviewed in the monthly/quarterly QAPI meeting.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 695	Continued From page 20	F 695		

Status indicating the resident's cognition was intact.

The admission physician's orders dated 7/4/19 included an order to administer oxygen at 2 liters as needed for shortness of breath.

The Comprehensive Person-Centered Plan of Care dated 7/4/19 identified the resident was at risk for sleep pattern disturbance. The goals listed were that the resident would not exhibit any sleep related behavioral symptoms and will express feelings of being well rested. One of the approaches listed was to administer oxygen (O2) as needed.

On 8/15/19 at 4:42 p.m., and during the initial tour of the facility on 8/14/19, the resident's oxygen concentrator located at the bedside was observed to be missing the plates on both sides of the cabinet that hold the external filters. These spaces were open allowing dust and other particulates to enter inside the concentrator cabinet. The Maintenance Director was asked to accompany this surveyor into the residents room to check the O2 concentrator. Upon observation of the missing parts he stated, "That should have a filter, it keeps the dust and whatever else down to a minimum from going into the system so it can continue to pump out fresh air." The sticker on the upper left corner of the cabinet indicated this concentrator had received it's annual maintenance and calibration check from the contracted oxygen supplier recently, on 8/8/2019.

On 8/15/19 prior to the resident getting up for ADL (activities of daily living) care she was asked if she uses the concentrator, she stated "Yes, I used it last night". The nurses notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICAT ON NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 695	Continued From page 21 8/15/19 entered at 9:25 p.m., and 00:35 a.m., evidenced the resident was receiving oxygen at 2 liters via the nasal cannula. 08/15/19 at 4:45 p.m., the Maintenance Director came into the conference room and stated, "I got another one (oxygen concentrator) to replace it." The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting conducted on 8/15/19. No additional information was provided to the survey team for Resident # 49 prior to exit.	F 695		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712	**F712** 1. **Resident #39 was seen by the physician.** 2. **An Audit was completed by the Medical Records to ensure that residents were seen by a physician once every 30 days for 90 days and every 60 days thereafter.** 3. **Administrator reeducated Medical Records and nursing staffing on the requirements for physician visits. Medical Director also received notification of the visiting requirements for physicians.** 4. **Medical Records/Designee will complete an audit weekly x 2 months to monitor for timeliness of physician visits.** 5. **Audits will be reviewed during the monthly/quarterly QAPI meetings.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 712	Continued From page 22 Based on observation, clinical record review, staff interview, the facility staff failed to ensure 1 of 35 Residents (#39) in the survey sample was seen by a physician or his/her designee at least every 60 days. Findings included: Resident #39 was originally admitted to the facility on 05/24/05. Diagnosis included but were not limited to *Chronic Pulmonary Edema and *Depression. Resident #39's Minimum Data Set (MDS), a quarterly with an Assessment Reference Date (ARD) of 07/05/19 coded Resident #39 Brief Interview for Mental Status (BIMS) score of 11 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #39 total dependence of two with toilet use and transfer, total dependence of one with bathing, extensive assistance of one with bed mobility, dressing and personal hygiene for Activities of Daily Living care. Review of the clinical record revealed Physician's progress notes only for 09/18/18 and 6/20/19. An interview was conducted with the Director of Nursing (DON) on 08/16/19 at approximately 3:50 p.m., who stated, "We were in the process of changing physician, and Resident #39 was missed." The DON said Medical Records is responsible for notifying the physician when a resident requires re-certification. She said when a resident is admitted to the facility; they are to be seen every 30 days x 3 months then every 60 days after.	F 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 712	Continued From page 23 On 08/16/19 at approximately 4:09 p.m., an interview was conducted with Medical Records. The surveyor asked how often should a resident be seen by the physician or his designee. She said every 30 days for the first 90 days then every 60 days after. She said the physician was made aware when Resident #39 needed to be seen but he just did not see her; I cannot explain why the physician did not see Resident #39. The Administrator and Director of Nursing was informed of the finding during a briefing on 08/16/19 at approximately 6:15 p.m. The facility did not present any further information about the findings. The facility does not have a policy for physician visits but follows the Center for Medicare & Medicaid (CMS) regulations. The following document was presented to the surveyor: (CMS Manual System) Titled: Frequency of physician visits (Effective November 28, 2017). -The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 thereafter. Definitions: *Pulmonary Edema is a condition caused by excess fluid in the flung. This fluid collects in the numerous air sacs in the lungs, making it difficult to breathe. * Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755 SS=D	Continued From page 24 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controllec 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 record review and staff interview the facility staff failed to provide pharmacy services to one resident (Resident #10) in the survey sample	F 755 F 755	**F755** 1. **Staff verified Resident #10 Kepra was available.** 2. **Residents receiving Kepra in facility are at risk.** 3. **Licensed staff were re-educated on policy and procedure of medication availability.** 4. **An audit of residents receiving Kepra will be completed 3x a week x2 months by D.O.N./Designee to ensure Kepra is available.** 5. **Audits will be reviewed during the monthly/quarterly QAPI meetings.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 25 of 35 residents. Resident #10 was not provided physician ordered Keppra (a medication used for the treatment of seizure disorder) due to the medication not being available. The findings included: The facility staff failed to ensure medications were available in accordance with physician orders. Resident #10 was admitted to the facility on 11/2/2013 with diagnoses of Alzheimer's Disease, muscle weakness, Parkinson's Disease, Convulsions, shortness of breath and dysphagia. A Quarterly Minimum Data Set (MDS) dated 05/29/19 assessed this resident as having unclear speech and not able to make herself understood. This resident rarely understood and rarely understood others. This residents vision was highly impaired. This resident was not assessed in the area of Brief Interview of Mental Status (BIMS). In the area of Activities of Daily Living this resident was assessed as requiring extensive assistance in the area of transfer, dressing, eating, toilet use and required two person physical assist. Resident #10 was coded in the area of Neurological as having Seizure disorder or Epilepsy. A review of Resident #10's Care Plan dated 6/10/19 indicated Resident #10 was at risk for falls due to poor sense of safety awareness related to diagnoses of Alzheimer's disease and diagnose of Seizures. Goal-Risk for falls will be minimized through next review. Interventions-Administer medication as ordered and monitor for sedation.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26 A review of the clinical records dated 2/3/19 indicated: "Resident did not receive scheduled Keppra MD aware. Called pharmacy and refill will be delivered tonight. A review of the Medication Administration Record (MAR) dated February 2019 indicated: "Keppra Solution 500 MG/5 ML (milligrams/milliliters), give 5 ml via G-tube every 12 hours for seizures." The MAR indicated Keppra was to be administered at 0900 (9 AM) and 2100 (9 PM). The 9:00 AM hour for February 3 was noted with a (7) which indicated "other see nurses note." During an interview on 08/15/19 at 3:15 PM with the Director of Nursing (DON) she was asked was the medication available for Resident #10 and if Resident #10 received the medication. The DON stated, Resident #10 did not received the ordered medication nor was the medication available. A facility Medication Administration policy and procedure indicated: Policy "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medication Administration: 1. Medications are administered in accordance with writer orders of the Prescriber. "	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 758	Continued From page 27 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758	**F758** **1. Resident #27 was seen by Nurse Practitioner and new order was received.** **2. Residents on prn psychotropic medication residing in facility are at risk.** **3. Licensed staff were re-educated by D.O.N/Designee on policy and procedure of unnecessary psychotropic medications and prn use.** **4. An audit will be completed weekly x 2 months on prn psychotropic medications to ensure physician or prescribing practitioner evaluates the resident for the appropriateness of that medication every 14 days by D.O.N/Designee.** **5. Audits will be reviewed in monthly and quarterly QAPI Meetings** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 758	Continued From page 28 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure a PRN (as needed) psychotropic medication (Xanax-anxiety medication) was limited to 14 days for 1 out of 35 residents (Resident #27) in the survey sample who was receiving a PRN (as needed) psychotropic medication. The findings included: The physician did not do an evaluation of Resident #27 to extend the psychotropic medication past 14 days nor document the rational and duration in the resident's medical record. Resident #27 was originally admitted to the facility 02/28/19. Diagnosis for Resident #27 included but not limited to *Dementia without behavioral disturbances and Anxiety. Resident #27's MDS, a significant change with an Assessment Reference Date (ARD) of 06/18/19 coded resident with a BIMS score of 08 out of a possible 15 moderate cognitive impairment. In addition, the MDS with an ARD of 06/18/19, under section "E" (Behaviors), coded Resident #27 for exhibiting verbal behaviors directed towards others 1-3 days each week.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 758	Continued From page 29 Resident #27's comprehensive care plan documented resident for potential for drug related complications associated with use of psychotropic medications related to Anti-anxiety medication usage. Some of the goals set for the resident included not but not limited to: drug complications will be minimized through the next review (09/25/19). Some of the intervention to manage the resident's goal include provide medication as ordered by physician and evaluate for effectiveness and monitor for side effects and report to physician. Review of physician orders included the following order: 07/01/19: Xanax 1 mg-give 1 tablet by mouth every 8 hours as needed for anxiety monitoring for behaviors including crying, resisting care and yelling. The July 2019 Medication Administration Records (MAR's) evidenced documentation that the resident was administered the (PRN) Xanax 1 mg by mouth on the following days: 07/01, 07/02, 07/04, 07/05, 07/06, 07/07, 07/09, 07/10, 07/11, 07/13, 07/14, 07/16, 07/17, 07/19, 07/20, 07/21, 07/22, 07/23, 07/24, 07/25, 07/28, 07/29, 07/30 and 07/31/19. The August 2019 Medication Administration Records (MAR's) evidenced documentation that the resident was administered the (PRN) Xanax 1 mg by mouth on the following days: 08/01, 08/02, 08/03, 08/04, 08/05, 08/06, 08/07, 08/08, 08/10, 08/13, 08/14, 08/15 and 08/16/19. Review of Resident #27's clinical record for July and August 2019 did not show evidence the	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 758	Continued From page 30	F 758		

physician did an evaluation to extend the psychotropic medication past 14 days nor document the rational and duration in the resident's medical record.

An interview was conducted with the Director of Nursing (DON) on 08/16/19 at approximately 3:50 p.m. The DON stated, "I was focused on PRN antipsychotic medication. I was not aware the 14 days also included the psychotropic." The DON stated, "We were unable to locate documentation in the resident clinical record that Resident #27 was evaluated to continue the use of the (PRN) Xanax to be extended past the 14 days."

The Administrator and Director of Nursing was informed of the finding during a briefing on 08/16/19 at approximately 6:15 p.m. The facility did not present any further information about the findings.

The facility present the following policy titled Nursing Care Center Pharmacy - Medication Monitoring - Medication Management (Revision date: November 2017).

-Based on comprehensive assessment of a resident, the facility must ensure: PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rational in the resident's medical record and indicate the duration for the PRN order.

Definitions:

-Dementia is the name for a group of symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 758	Continued From page 31 caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (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 are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).	F 758		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation the facility staff failed to notify the physician and/or his designee of laboratory results for 1 of 35 resident (Resident #24) in the survey sample.	F 773	**F773** 1. **Resident #24 labs results been communicated to the Nurse Practitioner.** 2. **Residents with lab orders that reside in facility are at risk.** 3. **Licensed staff were re-educated by the D.O.N/Designee on timely notification to physician when lab results are abnormal.** 4. **D.O.N./Designee will be complete an audit 2x a week x 2 months to ensure appropriate and timely notification to the physician of lab results was completed and documented.** 5. **Audits will be reviewed in monthly and quarterly QAPI Meetings.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 773	Continued From page 32	F 773		

The findings included:

The facility staff failed to report to the physician Resident #24's abnormal lab results of a high Hemoglobin A1C (HgbA1C), resulting in a delay in medical treatment. Resident #24 was originally admitted to the facility on 03/06/19. Diagnoses for Resident #24 included but not limited to, Type 2 Diabetes Mellitus (DM.)

Resident #24's Minimum Data Set (MDS), quarterly assessment with an Assessment Reference Date of 06/12/19 coded the Brief Interview for Mental Status (BIMS) score an 03 out of a possible 15 indicating severe cognitive impairment. Resident is extensive assistance of one with bed mobility and bathing, limited assistance of one with dressing and personal hygiene and supervision with transfer and toilet use for Activities of Daily Living (ADL).

Resident #24's comprehensive care plan documented resident has alteration in blood glucose due to diagnosis of insulin dependent diabetes mellitus. Some of the goals set for the resident included not but not limited to: at risk for complications from diabetes will be minimized through the next review (11/11/19). Some of the intervention to manage the resident's goal include administer medication a ordered and labs per physician order and PRN for change in condition/manifestation of clinical signs or symptoms.

The clinical record revealed the following Medication Regimen Review (MMR) written on 06/19/19 to include the following current medication orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 773	Continued From page 33 -Glipizide 10 mg by mouth twice daily and Humalog sliding scale insulin. -The MMR for 06/19/19 also included - Please consider: HgbA1C to monitor this residents diabetic therapy. The Physician/Prescriber Responded to please draw HgbA1C, signed on 06/26/19. During the review of Resident #24's medical record, the surveyor was unable to locate the lab results for the HgbA1C ordered on 06/26/19. On 08/15/19 at approximately 9:45 a.m., the surveyor requested the HgbA1C lab results from the Director of Nursing (DON). On the same day at approximately 11:30 a.m., the DON stated, "The lab results were obtained but the physician was never informed of the results." She said the Nurse Practitioner (NP) is reviewing the lab results now." The surveyor was given a copy of the HgbA1C labs results that were obtained on 06/28/19 with the following results: -Results @ 8.1 (High). Normal range for HgbA1c (4.0-6.0). On 08/15/19, the surveyor was presented a progress note written by the NP on 08/15/19 to include the following new orders on Resident #24: -Start ACTOS 30 mg daily for DM. -Check BMP for Renal Function. -In 7 days after starting ACTOS-will decrease Glipizide to 5 mg twice daily for DM. An interview was conducted with the NP on 08/16/19 at approximately 2:55 p.m. The surveyor asked, "What is the purpose of a HgbA1C" she replied, "It gives a baseline on how well we are controlling the resident blood sugars	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 773	Continued From page 34	F 773		

and if they are being complaint with their diet." The surveyor asked, "If labs are ordered, when do you expect for the facility to inform of the results?" The NP stated, "I would expect the lab results in a few days but a least within a week." The resident did not experience any negative effects related to the lab result.

The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 08/16/19 at approximately 6:15 p.m. The facility did not present any further information about the findings.

Definitions:

-Hemoglobin A1C is a blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar, level over the past 3 months (https://medlineplus.gov/ency/article/007365.htm).

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

-Glipizide is used to treat type 2 diabetes - a condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood (https://medlineplus.gov/ency/article/007365.htm).

-Humalog insulin is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes (https://medlineplus.gov/ency/article/007365.htm).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 773	Continued From page 35 -ACTOS is an oral diabetes medicine that helps control blood sugar levels (https://medlineplus.gov/ency/article/007365.htm). -Basic metabolic panel (BMP) is used to check the status of a person's kidneys and their electrolyte and acid/base balance, as well as their blood glucose level-all of which are related to a person's metabolism.	F 773		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility documentation the facility staff failed to ensure that opened food products were properly dated, labeled, and stored in accordance with	F 812	**F812** 1. **Dietary Manager threw away the Med Pass and Thickened Orange juice.** **Dietary Manager dated and sealed the bag.** 2. **Residents residing in facility are at risk.** 3. **Dietary Manager re-educated the dietary staff on the requirements of labeling, storage and dating and of food.** 4. **Administrator/Designee will complete an audit 5 x a week x 4 weeks, 3 x a week x 4 weeks to monitor for proper labeling , storage, and dating.** 5. **Audits will be reviewed in the monthly/quarterly QAPI meeting.** **9/16/2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 36 professional standards for food service safety. The findings included: On 08/14/2019 at 11:15 a.m., during the initial tour of the kitchen with the Dietary Manager an open carton of *Med Plus 2.0 Vanilla (a fortified nutritional shake) and an opened carton of Thickened Orange Juice was observed in the reach in refrigerator. They were not dated with an opened date or use by date. The Dietary Manager was asked, "Should the staff date the cartons when they open them and date them with a use by date?" The Dietary Manager stated, "Yes, the staff should have dated them. They just forgot to date them." The Dietary Manager stated, "I will throw them away." At approximately 11:25 a.m., walked into the walk in freezer accompanied by the Dietary Manager and noted a cardboard box sitting on the shelf. The Dietary Manager was asked, "What is inside the cardboard box?" The Dietary Manager took the box down off the shelf and inside the box was an open plastic bag. The Surveyor asked the Dietary Manager to pick the plastic bag up out of the box to show the surveyor what was inside the bag. The surveyor noted that the bag was open and not dated or labeled. The Surveyor asked the Dietary Manager, "What is inside the bag?" The Dietary Manager stated, "Breaded Chicken Patties." The Dietary Manager was asked, "Should the bag be closed, sealed tightly?" The Dietary Manager stated, "Yes, someone forgot to close the bag." At 3:40 p.m. on 08/15/2019, the Surveyor revisited the kitchen and the Dietary Manager stated that he was in the process of inservicing the Dietary Staff on proper Dating and Labeling of	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 37 items. On 08/16/2019 at approximately 3:00 p.m., the Dietary Manager provided a copy of the inservice training information and the sign in sheet to the Surveyor. On 08/16/2019 at approximately 6:30 p.m., at the pre-exit meeting the Administrator and the Director of Nursing was informed of the finding. The facility did not present any further information about the finding. * Guidance from: https://www.hormelhealthlabs.com/resources/for-healthcare-professionals/product-protocols/med-pass-fortified-nutritional-shake-medication-pass-program/ IV. Implementation of MED PASS®* Program Procedure: 5. MED PASS® 2.0/MED PASS® NSA needs to be kept at refrigerated temperature (34-40 degrees F) once opened. If kept at this temperature range, product is good for 4 days from the time opened. If product is opened and not refrigerated, product should be discarded after 4 hours.	F 812		
F 880 SS=E	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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 38 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	F880 1. Cook #3, Cook #2, and Dietary Manager was educated on proper hand washing procedures. Resident #154 Foley catheter was secured and drainage bag was removed off of floor. 2. Residents residing in facility are at risk. Residents with Foley catheters residing in facility are at risk. 3. Administrator/Designee reeducated the Dietary Manager and staff on proper hand washing procedures. Nursing staff were re-educated by the D.O. N./Designee on the care of a Foley catheter. 4. Administrator/Designee will complete an audit 5 x a week x 4 weeks, 3 x a week x 4 weeks to ensure proper hand-washing procedures. A Foley catheter audit will be completed 3 x week x 2 months by D.O.N/Designee to ensure catheters are secured. Audits will be completed during care keeper rounds 5 x a week x 2 months observing for misplacement o tubing and Foley bags on the floor. 5. Audits will be reviewed during the monthly/quarterly QAPI meetings. 9/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 39 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document review the facility staff failed to perform hand hygiene practices to provide a safe, sanitary environment and to help prevent the development and transmission of disease and infections; and failed for one of 35 residents, Resident #154's, Foley catheter tubing and bag in a manner in accordance with infection control standards and practices to help prevent associated urinary tract infections. The findings included: 1. On 08/15/2019 during a follow up visit in the kitchen, the following observations were made: At approximately 11:50 a.m., Cook #3 was observed washing her hands with soap and water for 5 seconds.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 40 At approximately 12:00 p.m., Cook #2 was observed washing his hands with soap and water for 5 seconds. At approximately 12:10 p.m., the Dietary Manager was observed washing his hands with soap and water for 5 seconds. On 08/15/2019 at 1:00 p.m. the surveyor reviewed hand washing observations with the Dietary Manager. The Dietary Manager was asked, "When the staff wash their hands, how long do you expect them to wash them?" The Dietary Manager stated, "They should wash their hands for 20 seconds, sing Happy Birthday." At 3:40 p.m. on 08/15/2019, the Surveyor revisited the kitchen and the Dietary Manager stated that he was in the process of inservicing the Dietary Staff on proper handwashing. On 08/15/2019 at 3:45 p.m., an interview was conducted with Cook #2 and reviewed observing him wash his hands for 5 seconds. Cook #2 was asked, "When you wash your hands, how long should you wash them for?" Cook #2 stated, "I've been inserviced before and I should wash them for 20 seconds." On 08/16/2019 at approximately 3:00 p.m., the Dietary Manager provided a copy of the inservice training information and the sign in sheet to the Surveyor. On 08/16/2019 at approximately 3:00 p.m., a copy of the facility policy and procedure on "Hand Washing Technique (Refer to Lippincott)" with an effective date of 2/17 was provided to the Surveyor. Review of the policy and procedure revealed under Procedure #3 - "Apply soap to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 41	F 880		

hands. Using friction, wash all parts of hands, between fingers, knuckles and wrists for 10 to 15 seconds."

On 08/16/2019 at approximately 6:30 p.m., at the pre-exit meeting the Administrator and the Director of Nursing was informed of the finding. The facility did not present any further information about the finding.

2. The facility staff failed to handle Resident #154's Foley catheter tubing and bag in a manner in accordance with infection control standards and practices to prevent catheter associated urinary tract infections.

Resident #154 was admitted to the facility on 7/15/19 with an indwelling Foley catheter for diagnoses of BPH (benign prostatic hyperplasia-an enlarged prostate gland that can cause urination difficulty) and UTI (urinary tract infection). The Admission MDS (Minimum Data Set) with an assessment reference date of 7/22/19 coded the resident as having both long and short term memory deficits and severely impaired daily decision making skills. The resident was coded as having an indwelling catheter (a plastic tube inserted into the bladder to drain urine) and having received an antibiotic for 7 of 7 days of the look back period.

The physician order dated 7/15/19 was to administer Cipro (an antibiotic) 500 milligrams one tab twice a day for 14 days for the treatment of a UTI.

The Comprehensive Person-Centered Plan of Care dated 7/16/19 identified the resident had a potential for Urinary Tract Infection due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 42 presence of an indwelling catheter. The goal was the resident's risk for UTI will be minimized through the next review. Two of the interventions listed to achieve the goal was to provide indwelling catheter care every shift and as needed, and secure catheter and tubing appropriately. On 8/14/19 on initial tour at approximately 11:45 a.m., the resident was observed in bed with a towel over his head. The bed was in the lowest position, the catheter tubing and drainage bag were making contact with the fall mat on the floor. On 08/15/19 10:56 a.m., the resident was in the low bed, the catheter drainage bag was observed making contact with the floor. On 08/15/19 at 1:08 p.m., the resident was lying in bed, the Foley catheter bag was observed making contact with the floor mat. Registered Nurse #1 was asked to show the surveyor Resident #154's Foley catheter securement device. The RN palpated for the securing device through the resident's sweat pants and could not feel one. He lowered the resident's pants and observed that there was no securement device. The RN then went and obtained an anchor and secured the catheter. Further assessment of the catheter tubing entrance evidenced the resident had an elongated cleaved non open area. The bed was lowered after application of the anchor and the drainage bag was left making contact with the floor mat. A request for the facility's Indwelling Catheter management policy was made at this time. The nurse practitioners note dated 8/15/19 read, in part as follows:...(resident description) being	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 43 seen per staff request in regards to urethral erosion. Due to an indwelling Foley catheter. Upon assessment there was a well healed site from a previous catheter related wound... 08/16/19 9:53 a.m., observed the resident in bed, the bed was in the low position with the Foley drainage bag making contact on the floor. The unit manager was then asked to escort this surveyor into the room. The drainage bag position was pointed out to the unit manager. She stated the bag is on the floor, when asked why the bag should not be on the floor she stated, "Infection Control". A second request for the facility's policy on Indwelling Catheter management was made. The unit manager was also the facility's Infection Control Nurse. The facility did not have a policy or procedure on the management of an Indwelling Catheter. A copy of Lippincott Nursing Procedures eighth edition was provided to this surveyor by the Infection Control Nurse on 8/16/19 at 4:46 p.m., who stated, "We use this for our policy." Page 392 read, in part: Secure the catheter using a catheter securement device. If a securement device is not available, tape the catheter to the patient's abdomen or thigh to prevent pressure on the urethra...Don't place the drainage bag on the floor. The above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting on 8/16/19.	F 880		