STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BAY POINTE LLC	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/17/19 through 12/18/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 112 certified bed facility was 94 at the time of the survey. The survey sample consisted of 1 current Resident reviews (Resident #1) and 1 closed record review (Resident #2).	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to provide an ongoing activity program for 1 of 2 residents in the survey sample, Resident #2. The findings included: Resident #2 was admitted from home to the facility on 10/9/19 for long term care placement.	F 679	1. Resident #2 has discharged from the facility. 2. All residents have the potential to be affected. 3. A. Activity Director and Activity Assistant will be in-serviced on the following: 1. Documenting ongoing activity program based on identified residents' preferences. 2. Documenting residents' refusal to participate in out of room activities. 3. Documenting 1:1 activity program are provided and residents' participation. B. Activity Director and Activity Assistant will revise documentation tools for scheduled activity participation and 1:1 activity participation. C. 100% care plan audit to confirm documentation of person-centered approaches.	

			D. New admits and/or readmits care plans will be developed upon the completion of section "F" of the MDS. 4. A. Administrator will meet with the Activity Director and Activity Assistant weekly x 1 month to review documentation. B. Activity Director and/or designee will monitor documentation of activity participation, documentation of refusal to participate in out of room activities, and documentation of 1:1 activity program x 3 months and report results at QAPI meeting. C. Activity Director and/or designee will confirm completion of 100% care plan audit confirming person-centered approach and review results at QAPI meeting. D. Activity Director and/or designee will monitor completion of new admits and/or readmits care plans upon completion of section "F" of the MDS x 3 months and report results at the QAPI. 5. Date certain: January 31, 2020	

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

Sandra D. Dee — Administrator — 1/2/2020

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

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F 679		F 679		

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The resident's diagnoses included but not limited to, severe dementia, congestive heart failure, and difficulty walking. The admission Minimum Data Set (MDS) with an Assessment Reference Date of 10/16/19 coded the resident as having severely impaired decision making skills with long and short-term memory loss. The Activity Preference section F0500 primary respondent was the resident's family member. The resident preferences that were assessed and identified as very important included books, newspapers, magazines, keeping up with the news, doing things with groups of people, going outside to get fresh air when the weather is good, and participating in religious services or practices.

The Activity Comprehensive Person Centered Plan of Care indicated the resident would attend activities of interest/choice. The goal was that the resident would participate in 3-4 in or out of room activities a week, and the resident will initiate leisure activities 1-2 times/day such as visiting with family/friends and watching the news, target date 1/15/20. The interventions to achieve/maintain the goals were; inform of newspaper and daily chronicle availability in activity room, invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, provide an activity calendar in the resident room, and respect wishes to decline invitations when rest/leisure-type activities are preferred.

The complainant alleged that the resident was left in the room and not taken to the dining room to participate in activities.

A review of the clinical record and activity attendance/participation log for Resident #2 was

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F 679		F 679		
	Continued From page 2 conducted. There was no documented evidence that an ongoing activity program based on the resident's identified preferences was provided to the resident from 10/9/19 through 10/29/19, a total of three weeks. On 12/17/19 at 12:09 p.m., an interview was conducted with the Administrator. She stated that the family had brought up concerns to include activities during a meeting with her, the social worker, the Director of Nursing and the unit manager. The Administrator stated the family asked if the staff could get the resident out of the room to activities; she stated to them that she would speak to the Activities Director to see if she had offered activities and also told the family that the staff can encourage the resident to attend but can't force the resident to go. An interview with the Activities Director (AD) was conducted on 12/17/19 at 2:00 p.m. The Activities Director stated the resident was, "... more of a loner, he liked his newspaper." She indicated there was in issue at the beginning of the resident's admission with the newspaper not being delivered. She stated the facility did not provide newspapers for residents, the residents had to have their own subscription. She stated 1:1 (one to one) activities were provided and the resident was offered to attend planned activities and often refused. When asked if she invited the resident everyday she stated, "Not everyday." The Activities Director also stated the family had expressed concerns during the care plan meeting conducted on 10/23/19 about activities for the resident. The clinical record failed to evidence documentation of resident refusals, of out of room activities offered or that 1:1 activities were provided from 10/9/19 through 10/29/19.			

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F 679	Continued From page 3 The above findings was shared with the Administrator and the Director of Nursing on 12/18/19 during the pre-exit meeting. No additional information was provided prior to exit.	F 679		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to implement the Registered Dietician's recommendations to prevent unintended weight loss for 1 of 2 residents in the survey sample, Resident #2.	F 692	1. Resident #2 has discharged from the facility. 2. All residents have the potential to be affected. 3. A. The Registered Dietician will submit written nutritional recommendations to Director of Nursing, Unit Managers, Dietary Manager, and Administrator. B. Director of Nursing and/or designee will follow-up on all nutritional recommendations within forty-eight (48) hours of receipt. 1. Obtain MD order and/or document MD refusal to implement. 2. Submit dietary slip for new nutritional order to dietary department. 3. Review nutritional recommendations during the weekly Risk Management Meeting. 4. Director of Nursing and/or designee will monitor implementation of nutritional recommendations x 3 months and report results at the QAPI meeting. 5. Date certain: January 31, 2020	

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The findings included:

Resident #2 was admitted from home to the facility on 10/9/19 for long term care placement. The resident's diagnoses included but not limited to severe dementia, congestive heart failure, and difficulty walking. The admission Minimum Data Set (MDS) with an Assessment Reference Date of 10/16/19 coded the resident as having severely impaired decision making skills with long and short-term memory loss. The resident did not exhibit signs and symptoms of possible swallowing disorder, and the resident was not identified with weight loss of 5% in the last month or 10% in the last six months.

A physician note dated 4/8/19 from the resident's primary care giver prior to the residents admission to the facility evidenced the resident's usual weight was 132 pounds.

The Dietary/Nutritional note dated 10/16/19 by the Registered Dietitian (RD) working remotely, evidenced a "recommendation to add larger entrees with meals for weight maintenance at this time." The RD documented that the resident's current weight was 132 pounds with BMI (body mass index) 19 (low for age).

A second Dietary/Nutritional note dated 11/1/19 by the Registered Dietician (RD) working remote indicated the resident's current weight was 127.2 pounds. The RD documented, "Previous RD recs (recommendations) pending-will follow up. Continue to monitor and consult RD prn (as needed).

A third Dietary/Nutritional note dated 11/13/19 by the Registered Dietician (RD) on site documented

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"Recommend add large portions to meals to increase kcal (kilocalorie) intake and stabilize wt (weight)."

The resident's recorded weights in pounds were as follows:10/10/19=132, 10/11/19=132, 10/12/19=132.6, 10/29/19=127.2, 11/13/19=127.5; a loss of 4.5 pounds since admission.

The clinical record evidenced the RD's recommendation to add larger entrees on 10/16/19 and 11/1/19 were not implemented until 11/13/19.

The Director of Nursing was interviewed on 12/17/19 at 3:45 p.m., the failure to implement the RD recommendations was shared. She stated that RD was working remotely and did not communicate to the facility the recommendations. She stated that the RD should have called her or emailed her. A new on-site RD started working with the facility on 11/11/19.

On 12/18/19 at 10:25 a.m., the on-site RD was interviewed. She was asked in her professional opinion, could the resident's weight loss be contributed to the Lasix 20 milligrams once a day (a diuretic administered for the treatment of congestive heart failure). She stated, " In this particular situation probably not because (the resident) did not have edema." When asked why the recommendation for larger entrees was made, she stated, "The resident's weight was in the 130's, when I reassessed the weight was down to #127, it's not significant weight loss...he was eating at least 75% of meals."

The above findings was shared with the

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F 692	Continued From page 6 Administrator and the Director of Nursing during the pre-exit meeting conducted on 12/18/19. No additional information was provided prior to exit.	F 692		