STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/09/18 through 07/13/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that	E 004		8/8/18

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

Electronically Signed | 08/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 004	Continued From page 1 must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan Identified Risk Assessment. The findings included: During an interview on 7/12/18 at 10:40 A.M. with the Administrator, he was asked for documentation of the facilities community-based risk assessments that will assist the facility in addressing the needs of their patients. The administrator stated the facility had not conducted a risk assessment of it's Emergency Preparedness Plan. The facility staff failed to have documentation of identified risk assessments of the Emergency Preparedness Plan.	E 004	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency.. C.With respect to what systemic measures have been put in place to address the stated concern. "The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The plan has been communicated to all department leadership "Administrator ensured all disaster manuals contained updated information and are placed at each nurse□s station as well as administrator office, maintenance office and receptionist desk. "In-services staff on the emergency plan and location of the emergency plan binder D.With Respect to How the Plan of Corrective Measures will be monitored:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 004	Continued From page 2	E 004	"The administrator/QAPI committee will review and update emergency plan annually in accordance with CFR 483.73 "Our compliance is 8/8/18	
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced	E 006		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 006	Continued From page 3 by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan Identified Risk Assessment and Associated Strategies. The findings included: During an interview on 7/12/18 at 10:45 A.M. with the Administrator, he was asked for documentation of the facilities community-based risk assessments and strategies that will assist the facility in addressing the needs of their patients. The administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The facility staff failed to have documentation of Identified Risk Assessments and Strategies of the Emergency Preparedness Plan.	E 006	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. .The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. .The Plan was developed with facility-based and community-based risk assessment, utilizing an all-hazards approach including missing residents and is documented under E006 .Facility identified emergencies that are reasonable and arrangements that may be necessary to ensure essential services are provided during an emergency. D.With Respect to How the Plan of Corrective Measures will be monitored: .The administrator/QAPI committee will review and update emergency plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 006	Continued From page 4	E 006	annually in accordance with CFR 483.73 .Our compliance is 8/8/18	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The findings included: During an interview on 7/12/18 at 10:50 A.M. with the Administrator, he was asked for documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency; nor did the facility have	E 007	A.With respect to the specific residents cited: .No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. .All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. .The Administrator and facility leadership	8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 007	Continued From page 5 a complete list of staff identified as having delegation of authority during an emergency. The facility staff failed to have documentation of the facilities identified population at risk and documentation of delegation of authority during an emergency.	E 007	reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The Administrator and facility leadership has identified and documented the resident population at risk during an emergency. .The Administrator and facility leadership, including frontline staff have been in-serviced on the delegation of authority during an emergency. D.With Respect to How the Plan of Corrective Measures will be monitored: .The administrator/QAPI committee will review monthly and update delegation of authority based on the stability of staff. .compliance is 8/8/18	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities:	E 013		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 013	Continued From page 6 *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have develop and implement emergency policies and procedures based on the emergency plan and the communication plan. The findings included:	E 013	A. With respect to the specific residents cited: .No residents cited B.With respect to how the facility will identify residents with the potential for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 013	Continued From page 7 During an interview on 7/12/18 at 10:50 A.M. with the Administrator, he was asked for documentation of the facilities identified hazards within the facility's risk assessment and the facility's overall Emergency Preparedness Program. The administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency. The facility staff failed to develop policies and procedures based on the Risk Assessment and Communication Plan.	E 013	identified concern. .All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. .The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. .The Administrator and facility leadership has identified and documented the resident population at risk during an emergency. "The Administrator and facility leadership have identified what type of services the facility has the ability to provide in an emergency. .The Administrator and facility leadership, including frontline staff have been in-serviced on the delegation of authority during an emergency. D.With Respect to How the Plan of Corrective Measures will be monitored: .The administrator/QAPI committee will review monthly and update delegation of authority based on the staffing changes. .compliance is 8/8/18	
E 015	Subsistence Needs for Staff and Patients	E 015		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 015 SS=C	Continued From page 8 CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:	E 015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 015	Continued From page 9 (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have vendor contracts for sewage and waste disposal services and a fire watch process. The findings included: During a review of the emergency preparedness plan with the administrator on 07/12/18 at 11:01 A.M. the administrator was asked for documentation for vendor contracts for sewage and waste disposal services and the facilities fire watch process. The administrator stated "He did not have documentation of the facility having a fire watch process or sewage and waste disposal services." The facility staff failed to provide documentation of the Emergency Preparedness Plan vendor contracts for sewage and waste disposal services and a fire watch process.	E 015	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. "The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The facility has contracted with local waste disposal companies to manage sewage and refuse. "The facility has a documented fire watch	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 015	Continued From page 10	E 015	plan and log. The plan and form will be placed in the Emergency Plan binder located at the nurses stations, Administrators office, Maintenance office and receptionist desk D.With Respect to How the Plan of Corrective Measures will be monitored: "The administrator/QAPI committee will review annually and update changes. "compliance is 8/8/18	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in	E 018		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 018	Continued From page 11 the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 018	Continued From page 12 secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation for the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency. The findings included: During review of the facilities Emergency Preparedness Plan on 07/12/18 at 11:09 a.m. the administrator was asked to provide documentation that facility staff have been trained on the facilities system to track the location of on-duty staff and sheltered resident who are relocated during an emergency. The administrator stated, "We have not trained our staff on the tracking system." The facility staff failed to train staff on the system to track the location of on-duty staff and sheltered residents who are relocated during an emergency.	E 018	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. "The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The facility has a tracking form for all residents NHICS 260Resident Evacuation Tracking Form "The facility has developed a tracking log for residents and staff "Nurses and facility leadership have been in-serviced on what forms will be used to track staff and residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 018	Continued From page 13	E 018	D.With Respect to How the Plan of Corrective Measures will be monitored: "The administrator/QAPI committee will review annually and update changes. "compliance is 8/8/18	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:	E 022		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 022	Continued From page 14 Based on record review and staff interview, the facility staff failed to have in it's Emergency Preparedness Plan documentation of the procedure for sheltering in place. The findings included: During an interview with the administrator on 07/12/18 at 11: 27 A.M. the administrator was asked for documentation of the procedure for sheltering in place for staff, volunteers and visitors. The administrator stated, he did not have documentation for sheltering in place for staff, volunteers and visitors. The facility staff failed to have documentation for sheltering in place for staff, volunteers and visitors.	E 022	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. "The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The facility has implemented policies and procedures and the criteria for sheltering in place. D.With Respect to How the Plan of Corrective Measures will be monitored: "The administrator/QAPI committee will review annually and update changes. "compliance is 8/8/18	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must	E 026		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 026	Continued From page 15 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have in it's Emergency Preparedness Plan documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the administrator on 07/12/18 at 11:37 a.m. the administrator was asked for documentation describing the facilities role in providing care in an alternate care site. The administrator stated, he did not have any documentation describing the facilities role or the	E 026	A. With respect to the specific residents cited: •No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. •All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 026	Continued From page 16 care that would be provided at an alternate care site. The facility staff failed to have documentation describing the facilities role in providing care in an alternate care site.	E 026	•The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. •The facility has written policy and procedure which describes its role in providing care at alternate care sites during an emergency. •The facility will provide staffing, supplies and services as directed through our Healthcare Coalition MOU or directed by local emergency manager. D.With Respect to How the Plan of Corrective Measures will be monitored: •The administrator/QAPI committee will review annually and update changes. •compliance is 8/8/18	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced	E 035		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 035	Continued From page 17 by: Based on record review and staff interview, the facility staff failed to have a method for sharing information of the Emergency Preparedness Plan with residents and families. The findings included: During an interview on 07/12/18 at 12:11 P.M. with the administrator, he was asked how did the facility share information with residents and families. The administrator stated, the facility had not informed residents nor families about the emergency preparedness plan. The facility staff failed to have a method to share information of the Emergency Preparedness Plan with residents and families.	E 035	A.With respect to the specific residents cited: "No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. "All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. "The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. "The facility has informed families about our emergency preparedness program via letter sent 8/6/18. Current residents have been given the same notice and new admission will receive the notification in the admission packet. D.With Respect to How the Plan of Corrective Measures will be monitored: "The Administrator/representative will audit notice was given during morning meeting for 4 weeks. "compliance is 8/8/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 036	Continued From page 18	E 036		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing	E 036		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 036	Continued From page 19 and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency Preparedness Training and Testing Program. The findings included: During an interview on 07/12/18 at 12: 17 a.m. with the administrator, he was asked for documentation of the facilities Emergency Preparedness Training and Testing Program. The administrator stated, the facility had not developed a training and testing program. The facility staff failed to have a training and testing program.	E 036	A.With respect to the specific residents cited: •No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. •All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. •The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. •In-service staff and vendors on the updated emergency plan. Discuss the facility/community risks and where to locate the emergency plan. •Implement training into new hire onboarding •The facility will conduct drills/exercises to identify gaps and areas of improvement. Fire drills will be conducted at least once every three (3) months on each shift so that all three (3) shifts participate in one (1) drill each quarter. Documentation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 036	Continued From page 20	E 036	these drills/exercises are reviewed during monthly Safety Committee meetings. Evacuation Drills are conducted semi-annually; one internal (i.e. fire, explosion, gas leak,..) and one external (i.e…tornado, bomb threat, intruders,…). One of these drills must include, at a minimum, moving residents from the affected area to another location •The facility will document all emergency training D.With Respect to How the Plan of Corrective Measures will be monitored: •Monthly audit for twelve months to validate compliance with education. Audits to be discussed at monthly QAPI meeting •compliance is 8/8/18	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs	E 037		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 037	Continued From page 21 at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 037	Continued From page 22 (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 037	Continued From page 23 alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an Initial Emergency Preparedness Training Program.	E 037	With respect to the specific residents cited: •No residents cited	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 037	Continued From page 24 The findings included: During an interview on 07/12/18 at 12: 22 P.M. with the administrator, he was asked for documentation for an Initial Training Program in Emergency Preparedness policies and procedures for all new new and existing staff. The administrator stated, the facility had not conducted an Initial Training Program for Emergency Preparedness. The facility staff failed to have an Initial Emergency Preparedness Training Program.	E 037	B.With respect to how the facility will identify residents with the potential for the identified concern. •All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to address the stated concern. •The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. •In-service staff and vendors on the updated emergency plan. Discuss the facility/community risks and where to locate the emergency plan. •Implement training into new hire onboarding •The facility will conduct drills/exercises to identify gaps and areas of improvement. Fire drills will be conducted at least once every three (3) months on each shift so that all three (3) shifts participate in one (1) drill each quarter. Documentation of these drills/exercises are reviewed during monthly Safety Committee meetings. Evacuation Drills are conducted semi-annually; one internal (i.e. fire, explosion, gas leak,..) and one external (i.e…tornado, bomb threat, intruders,…). One of these drills must include, at a minimum, moving residents from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 037	Continued From page 25	E 037	affected area to another location. D.With Respect to How the Plan of Corrective Measures will be monitored: •Monthly audit for twelve months to validate compliance with education. Audits to be discussed at monthly QAPI meeting •compliance is 8/8/18	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 041	Continued From page 26 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park,	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 041	Continued From page 27 Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have in it's Emergency Preparedness Plan documentation and a written agreement with an outside fuel source vendor. The findings included: During an interview on 07/12/18 at 12:33 P.M. with the administrator he was asked for documentation for written agreement with an outside fuel vendor for emergencies. The administrator was not able to provide a written contract for an outside fuel vendor.	E 041	A.With respect to the specific residents cited: •No residents cited B.With respect to how the facility will identify residents with the potential for the identified concern. •All residents at the center have the potential to be affected by this deficiency. C.With respect to what systemic measures have been put in place to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 041	Continued From page 28 The facility staff failed to have an written agreement for an outside fuel source vendor.	E 041	address the stated concern. •The Administrator and facility leadership reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. •The facility has an agreement for outside fuel and alternate power through Nixon Power Services Company D.With Respect to How the Plan of Corrective Measures will be monitored: •Emergency plan and contracts to be reviewed annually in accordance with CFR 483.73 •compliance is 8/8/18	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 07/09/18 through 07/13/18. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 169 certified bed facility was 140 at the time of the survey. The survey sample consisted of 38 residents in the sample, 34 current (#123, #82, #30, #17, #137, #34, #89, #45, #94, #9, #6, #13, #115, #62, #12, #81, #43, #107, #59, #135, #54, #41, #40, #1, #112, #127, #108, #101, #18, #39, #25, #128, #24, and #23)	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 29 and 4 closed (#139, #194, #245 and #294).	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 582	Continued From page 30 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 38 residents (Resident #101 and 126) in the survey sample. 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #101 who was discharged from skilled services with Medicare days remaining. 2. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #126 who was discharged from skilled services with Medicare days remaining. The findings included: 1. Resident #101 was readmitted to the nursing facility on 02/13/18. Diagnosis for Resident #101	F 582	A.With respect to the Specific Residents Cited: By 08/06/18, the responsible parties (RP) for the specific residents cited that still reside at the facility (#101 and #126) were notified by the administrator (ADM) or designee of the facility's policies related to receiving notification of charges for services not covered under Medicare/Medicaid. B.With Respect to How the Facility will Identify Resident with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 582	Continued From page 31 included but not limited to Chronic Kidney Disease - stage IV (kidney failure). Resident #101's Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) date of 5/23/18 coded Resident #101 a 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident with severe cognitive impairment. On review of the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review provided by the facility to surveyors it was noted that Resident #101 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), but the SNF ABN (CMS-10055) was never provided. Resident #101 started a Medicare Part A stay on 02/13/18 and the last covered day of this stay was 03/20/18. Resident #101 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #101 had only used 36 days of her Medicare Part A services. The resident's representative was informed verbally of the NOMNC on 3/18/18. An interview was conducted with Assistant Business of Manager (ABOM) on 7/11/18 at approximately 4:00 p.m., stated, "I misunderstood what was to be delivered to the resident upon discharge from skilled services; I thought it was only the one notice (NOMNC) but an ABN letter was never given to the resident or their representative.	F 582	standards regarding the provision of a receiving notification of charges for services not covered under Medicare/Medicaid. An audit of resident's that may have required this notification over the last 30 days will be done by facility Social Worker (SW) and Business Office Manager (BOM) or designee and completed by 08/06/18. Any concerns regarding the alleged deficient practice were addressed and corrected at the time of identification. Facility staff will respect resident rights for notification of services changes at all times. C.With Respect to What Systemic Measures have been put in place to Address the Stated Concern. By 08/08/18, the ADM/designee re-educated facility minimum data sets (MDS) staff, therapy manager (TM) and social worker (SW) on facility standards and correct forms (SNF ABN/CMS-10055 and NOMNC/CMS-10123) regarding the provision of a timely notification of any changes in charges for services not covered under Medicare/Medicaid before the change occurs. Newly hired clinical administrative and social services staff will receive this education during the orientation process and at least annually. D.With Respect to How the Plan of Corrective Measures will be monitored: The ADM or designee and Interdisciplinary Team (IDT) members will review changes in charges for services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 582	Continued From page 32 The Administrator was informed of the finding on 7/11/18 at approximately 4:10 p.m. The facility did not present any further information about the findings. 2. Resident #126 was admitted to the nursing facility on 1/16/18. Diagnosis for Resident #126 included but not limited to Hypertension (high blood pressure). Resident #126 Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) date of 4/25/18 coded Resident #126 an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident with moderate cognitive impairment. On review of the SNF Beneficiary Protection Notification Review provided by the facility to surveyors it was noted that Resident #126 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), but the SNF ABN (CMS-10055) was never provided. Resident #126 started a Medicare Part A stay on 1/16/18, and the last covered day of this stay was 3/2/18. Resident #126 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #126 only used 44 days of her Medicare Part A services. The resident's representative was informed verbally of the NOMNC on 2/28/18.	F 582	not covered under Medicare/Medicaid in the morning MDS meeting, Monday through Friday. The social worker (SW) or designee will audit changes, provide the necessary notification of providing the SNF ABN (CMS-10055) and an NOMNC (CMS-10123) and document the notification in the resident's medical record. The Administrator (ADM) will audit changes for proper notification, five times per week for 12 weeks using the Daily Stand-up Meeting form. The Manager on Duty (MOD) will audit on weekends using the MOD duty sheet. Issues are immediately reviewed by the IDT members for appropriate corrective actions. The ADM reports the results of the audit(s) to the Quality Assurance Performance Improvement (QAPI) Committee. Reported concerns will have interventions developed and appropriate actions taken by the ADM in conjunction with the QAPI Committee members. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 582	Continued From page 33	F 582		

An interview was conducted with Assistant Business of Manager (ABOM) on 7/11/18 at approximately 4:00 p.m., stated, "I misunderstood what was to be delivered to the resident upon discharge from skilled services; I thought it was only the one notice (NOMNC) but an ABN letter was never given to the resident or their representative.

The Administrator was informed of the finding on 7/11/18 at approximately 4:10 p.m. The facility did not present any further information about the findings.

The facility's policy and procedures titled Notice of Medicare Non-Coverage (NOMNC) effective: 3/1/2015.

Purpose: NOMNC will be delivered to a resident in accordance with the Medicare and Managed care guidelines as outlined in this policy. Skilled Nursing Facilities (SNF's) NOMNCs are presented to resident beneficiaries for purpose of alerting them that Medicare covered item(s) and /or services(s) are ending and for providing beneficiaries the opportunity to request an expedited determination form Quality Improvement Organization (QIO). A Detailed Explanation of Non-Coverage (DENC) is given when the QIO review is requested in order to provide the beneficiary with a more detailed explanation on why coverage is ending.

Procedure:
-Copies of the completed NOMNC are:
a. Given to the resident or the authorized representative who signed the NOMNC.
b. Signed original is paced in the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 582	Continued From page 34 medical record at the SNF. c. Placed in the ABN/NOMNC binder in the business office.	F 582		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide notice of Bed Hold	F 625	A.With respect to the Specific Residents Cited:	8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 35 and Reserve Bed Payment Policy for five Residents (Resident #6, #82, #89, #1, #108) in the survey sample. 1. The facility staff failed to provide notice of Bed Hold and Reserve Bed Payment Policy to Resident #6 upon discharge to the hospital. 2. The facility staff failed to provide notice of Bed Hold and Reserve Bed Payment Policy to Resident #82 upon discharge to the hospital. 3. The facility staff failed to provide notice of Bed Hold and Reserve bed Payment Policy to Resident #89 upon discharge to the hospital. 4. The facility staff failed to ensure that Resident #1 was made aware of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 1/23/18 and 6/12/18. 5. The facility staff failed to provide notice of Bed Hold and Reserve Bed Payment Policy to Resident #108 upon discharge to the hospital. The findings included: 1. Resident #6 was readmitted to the facility on 12/16/17 with diagnoses of muscle weakness, dysphagia, hypertension, diabetes, seizures, GERD, dementia, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessed this resident as having a Brief Interview for Mental Status (BIMS) score of 15 in the area of Cognitive Patterns (no cognitive impairment). In the area of Activities of Daily Living (ADL) this resident was assessed as requiring Supervision	F 625	By 08/08/18, the responsible parties (RP) for the specific residents cited that still reside at the facility (#1, #6, #82 and #89) were notified of facility standards regarding the provision of providing written notice of Bed Hold and Reserve Bed Payment Policy at the time of transfer of a resident for hospitalization or therapeutic leave. B.With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding the provision of providing written notice of Bed Hold and Reserve Bed Payment Policy at the time of transfer of a resident for hospitalization or therapeutic leave. Facility staff will respect resident rights for notification of bed hold policies at the time of transfer of a resident for hospitalization or therapeutic leave. C.With Respect to What Systemic Measures have been put in place to Address the Stated Concern. By 08/08/18, the staff development coordinator (SDC) or designee re-educated facility nursing, administrative staff and social worker (SW) on facility standards regarding the provision of providing written notice of Bed Hold and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 36 with Setup help in the areas of mobility, transfer, dressing, eating, and personal hygiene. A Care Plan dated 7/5/18 indicated: Resident Hoards items, she refuses to send items home and continue to have things brought in. Resident has pulmonary condition and has potential for difficulty breathing (shortness of breath). A review of the clinical records indicated Resident #6 requested to go to the ER. Resident stated that she has been having sob (shortness of breath) for a few days. Resident #6 was discharged to the hospital on 3/15/18. During an interview on 7/11/18 at 10:30 A.M. with the Third Floor Unit Manager, she stated, "Resident #6 was not provided with a Bed Hold Notice or a Reserve Bed Payment Policy. 2. Resident #82 was readmitted to the facility on 03/30/18 with diagnoses of cardiomyopthy, hypertension, dysphagia, B Cell Lymphoma, Bipolar Disorder and depression. A re-admission Minimum Data Set dated 5/14/18 assessed this resident as having hearing difficulty. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 10. In the area of Activities of Daily Living (ADL) this resident was assessed as requiring Total Dependence in the areas of Transfer, Dressing, and personal Hygiene. A Care Plan dated 5/31/18 indicated: Resident at risk for falls. Resident needs/requires assist in Transfer, bathing, dressing and incontinence	F 625	Reserve Bed Payment Policy at the time of transfer of a resident for hospitalization or therapeutic leave. The BED HOLD policy will be sent with transfer papers or sent to the resident/responsible party (RP) with 24 hours of transfer. Coies will be retained in the medical record. Newly hired clinical and administrative staff will receive this education during the orientation process and at least annually. D.With Respect to How the Plan of Corrective Measures will be monitored: The Interdisciplinary Team (IDT) members and the Director of Nursing (DON) will review compliance with providing written notice of Bed Hold and Reserve Bed Payment Policy at the time of transfer of a resident for hospitalization or therapeutic leave in the morning meeting, Monday through Friday. The Administrator (ADM) will audit for proper notification, five times per week for 12 weeks using the Daily Stand-up Meeting form. The Manager on Duty (MOD) will audit on weekends using the MOD duty sheet. Issues are immediately reviewed by the IDT for appropriate corrective actions. The ADM reports the results of the audit(s) to the Quality Assurance Performance Improvement (QAPI) Committee members. Reported concerns will have interventions developed and appropriate actions taken by the ADM in conjunction with the QAPI Committee. When current interventions are not producing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 37 care. A review of the clinical records indicated on 4/6/18, Resident #82's son wanted resident to be sent to ER, requesting resident to be admitted to psych floor. Physician gave order to send resident to ER. During an interview on 7/11/18 at 10:30 A.M. with the Third Floor Unit Manager, she stated, "Resident #82 was not provided with a Bed Hold Notice or a Reserve Bed Payment Policy. 3. Resident #89 was readmitted to the facility on 5/14/18 with diagnoses of coronary heart disease, anemia, diabetes, depression, hypertension, CVA, and GERD. A Quarterly Minimum Data Set (MDS) dated 5/23/18 assessed this resident as having short term memory loss. In the area of Cognitive Skills for daily Decision Making this resident was assessed as having moderately impaired decision making regarding tasks of daily life. In the area of Activities of Daily Living (ADL) this resident was assess as requiring total dependence in the areas of transfer, mobility, dressing and personal hygiene. A Care Plan dated 5/18/18 indicated: Resident at risk for aspiration as resident has a Peg Tube. A review of the clinical records indicated on 5/8/18 resident's grand daughter notified nurse of patient shaking and having a substance coming from patients mouth noted what looked like feeding tube residual coming from patients mouth	F 625	desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 38	F 625		

or possible vomiting. Physician notified and agreed to send patient to hospital for further examination in respect to family wishes.

During an interview on 7/11/18 at 11:30 A.M. with the Second Floor Unit Manager, she stated, "Resident #89 was not provided with a Bed Hold Notice or a Reserve Bed Payment Policy.

4. Resident #1 is a 60 year old that was admitted to the facility originally on 3/1/17 and re-admitted on 2/2/18 and again on 6/14/18. Resident #1's diagnoses included Chronic Kidney Disease and Diabetes Mellitus.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 6/22/18. The Brief Interview for Mental Status (BIMS) for Resident #1 was a 4 out of a possible 15 which indicated the resident was severely cognitively impaired.

Resident #1's Progress notes for 1/23/18 and 6/12/18 were reviewed and are documented in part, as follows:

Date: January 23, 2018
Resident loa (leave of absence) via medical transport on stretcher, call received from dialysis that resident was being transported to ER (Emergency Room) for eval (evaluation) and treatment RP (responsible party) notified.

Date: June 12, 2018
Received report from (name) at (Dialysis Center Name) via phone that resident completed 20 minutes of treatment when Resident's B/P (blood pressure) dropped to 87/50, resident was unresponsive and vigorous sternum rub was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 39	F 625		

effective, Resident was sent to (Hospital Name) via 911 when EMT's (emergency medical team) arrived resident was reported back at baseline, awake with a B/P of 194/80 resident c/o (complained of) headache and slurred speech noted by (Dialysis Center Name) staff.

On 7/12/18 at 11:00 AM an interview was conducted with the Director of Nursing and she was asked if Resident #1's Responsible Party was notified of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 1/23/18 and 6/12/18. The Director of Nursing stated, "I don't see anywhere in the nurse's notes that the family was made aware of the bed hold at discharge." The Surveyor asked the Director of Nursing who was responsible for notifying the resident/responsible party of the bed hold at discharge. The Director of Nursing stated, "The nurses' on the floor are responsible for notifying the family's of bed holds."

On 7/12/18 at 11:30 AM the Director of Nursing came to surveyor and stated, "I spoke with the nurse and bed holds were not discussed with the family when the resident was discharged."

On 7/12/18 at 12:15 PM an interview was conducted with Licensed Practical Nurse (LPN) #7 who was a floor nurse on Resident #1's unit. LPN #7 was asked if she notify's the resident/responsible party of the bed hold policy and reserve bed payment policy upon transfer/discharge to the hospital. LPN #7 stated, "No the nurse's don't do that, that is done through the business office."

The facility policy titled "Facility Bedhold" was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 40	F 625		

reviewed and is documented in part, as follows:

POLICY STATEMENT
The facility will notify the resident/responsible party of the facility's bed hold and re-admission policies at admission and anytime a resident is transferred to the hospital or goes out on a therapeutic leave.

Bed Hold:
1. The facility's bed hold and re-admission policies will be discussed with the resident/responsible party and the facility will provide written notice of the bed hold and re-admission policies:
*Before a resident's transfer to the hospital or for overnight therapeutic leave and included in the resident's transfer packet. The facility's clinical team will facilitate the resident's transfer packet. The facility's business office team or designee will document verbal and written notification in the medical record.

On 7/13/18 at 11:15 AM a pre-exit conference was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator stated, "Yes, this is a system wide failure." Prior to exit no further information was shared.

5. Resident #108 was originally admitted to the facility 4/23/18 and readmitted 5/24/18 from a local acute care hospital, after repair of a hip fracture. The current diagnoses included; a left hip fracture, advanced dementia and an anxiety disorder.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 41	F 625		

(ARD) of 5/31/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making.

A clinical note dated 5/21/18, at 5:41 a.m., revealed a Certified Nursing Assistant (CNA) found Resident #108 lying on the floor, on her back. The note also stated the resident was assessed to be alert yet confused, the left leg appeared externally rotated and the resident was crying out in severe pain. Another note dated 5/21/18 at 6:47 a.m., read; the nursing supervisor was made aware of the resident's transfer to a local hospital's emergency room and the supervisor notified the Director of Nursing. A note dated 5//21/18 at 3:03 p.m., stated the physician was notified the resident had been admitted to the local hospital with a diagnosis of a left hip fracture.

On 7/12/18 at approximately 12:15 p.m., an interview was conducted with the Social Worker. The Social Worker stated she notifies the Ombudsman of discharges but she does not manage notifications of the bed hold policy because the facility staff decided discharges could be at any hour of the day therefore; the bed hold notification would become a nursing staff responsibility since they would be speaking with Resident Representatives and/or Resident at the time of a discharge.

There was no documentation stating the facility staff notified Resident #108 and/or the Resident Representative of the bed hold policy when she was admitted to the hospital, 5/21/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 42 On 7/12/18, at approximately 2:30 p.m., the above information was shared with the Administrator and Director of Nursing. The Administrator stated the bed hold notification procedure had resulted in a system failure and they would develop a more effective plan.	F 625		
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 interviews, facility documentation review and clinical record review the facility staff failed to accurately complete each required section of the MDS (Minimum Data Set) assessment for 2 out of 38 residents (Resident #126 & #135) in the survey sample. 1. The facility staff failed to complete the required section of Resident #126 quarterly MDS: section C-Brief Interview for Mental Status. 2. The facility staff failed to code Resident #135 for hospice care. The findings included: Resident #126 was admitted to the facility on 01/16/18. Diagnoses for Resident #126 included but are not limited to Hypertension (high blood pressure). Resident #126 MDS with an Assessment Reference Date (ARD) of 4/25/18 coded the	F 641	A.With respect to the Specific Residents Cited: A care plan conference by the Interdisciplinary Team (IDT) members was held on for Resident #135 with Hospice provider in attendance on 7/18/18. A care plan conference by the Interdisciplinary Team (IDT) members was held on for Resident #126 on 7/26/18. MDS Assessments, Care Plans and CNA Care Reports were revised as necessary to accurately reflect the resident's status. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding accuracy of assessments. By	8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 43 resident's Brief Interview for Mental Status (BIMS) score 11 of a possible 15 with moderate cognitive impairment. Review of the quarterly MDS with ARD of 06/13/18 noted it was marked with dashes under section C-Brief Interview for Mental Status. On 07/12/18 at 8:10 a.m., an interview was conducted with MDS Coordinator #2 regarding the dashes on Resident #126 quarterly MDS with ARD date 06/13/18. The surveyor asked the MDS coordinator what the dashes mean on the MDS, she replied, "That section was not assessed or no information was provided. The surveyor asked if section C on the 6/13/18 MDS should have been completed she replied, "Yes." The review of section Z on the 6/13/18 quarterly MDS was reviewed with the following information: the Social Worker (SW) had signed off on 6/14/18 that section C was completed. The following sections of the MDS were marked with dashes: Under Section C - C0100 - Brief Interview for Mental Status, section C0200, C0300 -Temporal Orientation (section A, B, C), section C0400, C0500, C0600, C0700, C0800, C1000, C1300, C1600 all coded with dashes. An interview was conducted with MDS Coordinator #1 on 8:25 a.m. The surveyor asked, "Do you check to make sure MDS sections are completed, she replied, "Yes." The surveyor informed the MDS #2 that section C on MDS with ARD date of 6/13/18 under section C was not completed, she then replied, "I check section Z to make sure they have signed off for being completed."	F 641	08/03/18, an audit (using the CMS-802 form) of all facility residents receiving hospice services was performed by DON/designee. By 8/8/18, the SW/designee audited MDS assessments done over the last 30 days for completeness on section Z. Any issues identified were addressed. C.With Respect to What Systemic Measures have been put in place to address the Stated Concern. By 08/08/18, the social worker (SW), MDS staff and SDC was re-educated by the DON regarding facility policy on coordination of hospice service and care plan involvement and the necessity of inviting hospice representatives to care plan meetings. MDS, quality of life manager (QLM) and SW were re-educated on the requirement to provide complete and accurate assessments with the time frame they are due. Newly hired SW, MDS staff and activities managers will receive this education during the orientation process and at least annually. The MDS Coordinator will audit the completeness of assessments as they are done weekdays, prior to signing off and submitting. D.With Respect to How the Plan of Corrective Measures will be monitored: The MDS Coordinator or designee will monitor care plan conference calendar weekly for meetings that require hospice participation, verify the provider was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 44 An interview was conducted with SW on 7/12/18 at approximately 8:30 a.m., who stated, "I do not know what happen but section C should have been completed." The facility Administrator was informed of the findings during a briefing on 7/12/18 at approximately 2:40 p.m. The facility did not present any further information about the findings. Facility policy titled Resident Assessment (Revised June 2017). -Guideline: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The assessment coordinator will be responsible for assigning sections of the MDS to be completed by the interdisciplinary team. Sections can be assigned and reassigned as appropriate and determined by the MDSC. a. MDS sections can and will have multiple disciplines assigned. b. General assign sections by discipline read in part: Social Service - C,D,E,Q -Individuals who complete a portion of the assessment must sign and certify the accuracy of the area/item of the assessment per the RAI Manual 3.0. Signatures must in include their title, area/item completed and date they completed that area/item of the assessment. -A Registered nurse will sign and certify that the assessment is completed per the RAI Manual.	F 641	invited by documenting contact information into conference notes and report aberrant findings at monthly QAPI Committee meeting. Necessary interventions are developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee members. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee members will develop alternative interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 45	F 641		

2. Resident #135 was originally admitted to the facility 7/24/13 and has never been discharged from the facility. The current diagnoses included; anemia, diabetes, and dementia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of 15. This indicated the resident was with moderately impaired daily decision making abilities.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, total care of 1 person with personal hygiene, bathing and dressing.

In section "O0100K2"of the 3/16/18 MDS assessment; the resident was not coded for hospice care while a resident.

A physician order dated 12/12/17 revealed an order for evaluation and treatment for hospice services.

On 7/12/18 at approximately 4:30 p.m., the MDS Coordinator stated the 3/16/18, MDS assessment was not coded for hospice care but the 6/15/18, MDS assessment was coded for hospice care. The MDS Coordinator stated a modification was made to the 3/16/18 MDS assessment and presented a copy of the modified assessment.

The active care plan dated 6/21/18 had a problem reading the resident elected hospice care.

The facility's guideline titled; Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 46 Assessment with a revision date of June 2017 read; the facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. At #4 the guideline read; the assessment process includes direct observation and communication with the resident, resident's family or legal guardian, as well as communication with licensed and non-licensed direct care staff members. On 7/12/18, at approximately 2:30 p.m.,the above findings were shared with the Administrator and Director of Nursing. An opportunity to present additional information was offered but none was provided.	F 641		
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	F 657		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, facility document review and staff interviews the facility failed to revise the Person Centered Care Plan's for 2 of 38 Resident's in the Survey Sample, Resident #34 and Resident #108. 1. The facility staff failed to revise Resident #34's Person Centered Care Plan in the area of Activities to include the resident's assessed activities of preference. 2. The facility staff failed to review effectiveness of interventions and review/revise Resident #108's person centered care plan after a fall resulting in a left hip fracture. The Findings Included: 1. Resident #34 is a 57 year old admitted to the facility 4/26/16 with diagnoses to include Depression and Dementia. The most recent Comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 5/3/18. The Brief Interview for Mental Status (BIMS) for Resident #34 was attempted but unable to be completed by the Resident. Under Section C Cognitive Patterns Resident #34 was coded to	F 657	A.With respect to the Specific Residents Cited: Resident #108 no longer resides at the facility. On 7/12/18, the MDS coordinator and quality of life manager reviewed and revised the person-centered care plan for resident #34 to reflect goals and interventions for activities. This resident was assessed by the MDS Coordinator as to the practice of not having the care plan revised for activities of preference and no negative outcomes were revealed. B.With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents are at risk for the deficient practice of failure to revise care plans to address activities preferences, interventions for fall risk and other needs. The MDS Coordinator/designee and IDT will review care plans for all residents after each new and quarterly assessments are done for to ensure accurate goals, statements and interventions are documented on the care plan. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

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

have long and short term memory problems. Resident #34 was also coded to be severely impaired in cognitive skills for daily decision making. Under Section F Preferences for Customary Routines and Activities the following activities were coded as Very Important for Resident #34: having books, newspapers, and magazines to read, listen to music you like, keep up with the news, and participate in religious services and practices. Under Section F Preferences for Customary Routines and Activities the following activities were coded as Somewhat Important for Resident #34: be around animals such as pets, do things with groups of people, do your favorite activities, and go outside to get fresh air when the weather is good.

Resident #34's Comprehensive Care Plan last revised 5/8/18 was reviewed and is documented in part, as follows:

Problem: Name (Resident #34) needs 1:1 (one to one) attention for activity stimulation; Spends most of the time in bed watching tv (television), listens to music, enjoys playing games on tablet, and daily visits from mother.

Approach:
1. Provide leisure supplies to self direct pursuits.
2. Obtain prior level of activity involvement and interests by talking with resident,staff, family.
3. Consider impact of medical problems on activity level.

Resident #34's One to One Participation Log for July 2018 was reviewed and is documented in part, as follows:

inaccuracies identified will be corrected by reviewing and updating the care plans to reflect the residents' current clinical status and are person-centered and individualized.

C.With Respect to What Systemic Measures have been put in place to Address the Stated Concern.

From 07/14/18 through 08/08/18, the clinical staff were re-educated by the SDC/designee on the importance of correctly completing the residents' care plans, including facility standards regarding the requirement for completing an accurate interim care plan within 48 hours of admission. From 07/14/18 through 08/08/18 Clinical and activities staff were re-educated by the SDC/designee on the requirement to know the person-centered care plans of the residents they provide care for. From 07/14/18 through 08/08/18 Clinical staff was re-educated by the SDC/designee on facility policies, procedures and standards for event management, including the need to attempt to determine a root cause after any event and the design specific prevention intervention(s) that mitigate risk for reoccurrence. Intervention(s) will be documented on the residents care plan and CNA care report as needed. Newly hired clinical staff will receive this education by the SDC during the orientation process and at least annually.

Any resident identified as needing to revise care plans as a result of an event,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 49 Resident #34 was coded as A (Active Participation) for the following activities: Art/Crafts- 7/2/18 Beauty/Grooming- 7/2/18, 7/6/18, 7/7/18, 7/9/18, and 7/11/18. Visual Stimulation- 7/2/18, 7/6/18, 7/7/18, 7/9/18, and 7/11/18. Lotion/Aromatherapy- 7/7/18 and 7/9/18. Music Tapes-no entries. Spiritual/Prayer/Chaplain Visit- no entries. On 7/12/18 at 10:00 AM an interview was conducted with the Activities Director. The Activities Director was asked who was responsible for updating/revising the Resident's Person Centered Care Plans for Activities. The Activity Director stated, "The Activities Director is responsible for updating the activities care plan either during or after the care plan meeting. I have only just taken over as the Activities Director a few days ago I was the Admissions Director and I'm still training the new Admissions Director. I haven't updated any care plans yet. My activity assistant can probably tell you more." On 7/12/18 at 10:30 AM an interview was conducted with the Activities Assistant. The Activities Assistant was asked if she updated Resident #34's Person Centered Care Plans for Activities or if she looks at the care plan to see the resident's activity preferences prior to carrying out activities with the resident. The Activities Assistant stated, "No I don't know anything about Name (Resident #34's) care plan, and no absolutely not I just go by what's on the activity log sheet for the resident. We have had over 5 different Activity Director's in the last year."	F 657	goal or intervention at risk for any negative outcome are discussed in the morning meeting, Monday through Friday. This discussion assures that appropriate interventions are written on the care plans. The IDT team meets weekly to discuss the accuracy of the care plans completed that week using the care plan conference worksheet. Any inaccuracies are corrected by the MDS Coordinators, unit managers and/or the DON/designee. The charge nurses will monitor events on weekends by following the facility's event management policies, procedures and protocols (including the need to establish root cause, develop a prevention intervention and document in medical record and 24 hr report) and report issues to the DON. D.With Respect to How the Plan of Corrective Measures will be monitored The MDS Coordinator will report the care plan meeting results to the DON. The DON/designee is responsible for monitoring the process by reviewing the EMR dashboard in morning meetings Monday thru Friday and directing the MDS coordinator to correct any inaccurate findings. The DON/Designee reports issues and concerns to the QAPI committee members for resolution. The ADM/DON in conjunction with the QAPI committee members, when necessary, will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 50	F 657		

On 7/12/18 at 11:45 the Activities Director provided the surveyor with a revised Person Centered Care Plans for Activities for Resident #34 which was reviewed and documented in part, as follows:

Problem:
Resident exhibits strong reluctance to be out of room for group activities as evidenced by outburst, stammering and agitation within group settings.

Approach:
1. Use soft touch and gentle massages for at least 2 minutes during 1:1 visits.
2. Introduce yourself to resident and use calm slow approach.
3. During visits, offer snack, open blinds, raise head of bed up and engage resident in reality orientation.
4. At least one visit per week read daily bread to the resident and gain recognition with responses.
5. Offer out-of-room, one-on-one quite activities such as sitting on the patio when up in chair.
6. Observe resident for signs of escalating tension, anxiety and overstimulation.
7. Resident enjoys watching tv throughout the day. Ensure that the tv is within comfortable viewing before exiting the room.

The facility policy titled "Care Plans-Comprehensive" effective date 10/31/17 was reviewed and is documented in part, as follows:

POLICY STATEMENT
A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 51	F 657		

psychological needs is developed for each resident. The care plan will include how the facility will assist the resident to meet their needs, goals and preferences.

2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the Resident Assessment Instrument.

4. Each resident's comprehensive care plan is designed to:
d. Reflect the resident's expressed wishes regarding care and treatment goals.

13. Care plans are ongoing and revised as information about the resident and the resident's condition change.

The facility policy titled "Activity Care Plans" effective date 7/25/17 was reviewed and is documented in part, as follows:

POLICY STATEMENT
An individual comprehensive and person-centered care plan including measurable objectives and timetables is developed for each resident based on the comprehensive assessment and the preferences of the resident to enhance his/her sense of well-being.

GUIDELINE:

2. The Quality of Life Director/designee will coordinate development of the activity care plan to support each resident's choice of activities including group, individual, and independent activities designed to meet the interests of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 52	F 657		

4. The resident's interests, hobbies, and cultural preferences will be incorporated in the development of the care plan.

5. The Quality of Life Director/designee will review the care plan at least quarterly; and as appropriate, revise the resident's care plan as indicated.

On 7/13/18 at 11:15 AM a pre-exit conference was conducted with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing was asked what she would have expected for Resident #34's Person Centered Care Plan. The Director of Nursing stated, "They should be updated to reflect the resident in realtime, what is going on today." Prior to exit no further information was shared.

2. Resident #108 was originally admitted to the facility 4/23/18 and readmitted 5/24/18 from a local acute care hospital, after repair of a left hip fracture. The current diagnoses included; a left hip fracture, advanced dementia and an anxiety disorder.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making.

In section "D" (Mood) the resident is coded for a poor appetite. In section "E" (Behavior), Resident #108 is coded for verbal aggression which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 53	F 657		

significantly interferes care, activities and socialization as well as rejection of care 1-3 days each week. In section "G" (Physical functioning) the resident was coded as requiring total care of 1 with off unit locomotion, personal hygiene and bathing, extensive assistance of 2 people with bed mobility, transfers, dressing, and toileting. She requires extensive assistance of 1 person with on unit locomotion, and supervision after set-up with eating.

The clinical record and the fall report revealed on 5/21/18, staff heard a loud noise and found Resident #108 on the floor in her room complaining of left hip pain. The resident was diagnosed with a left hip fracture at the local hospital.

The Fall Risk Evaluation, dated 5/24/18 scored Resident #108 at 22 (the evaluation stated a score of 10 or higher is at risk for falls).

Review of the undated active care plan revealed the facility staff failed to review the previous fall which resulted in the hip fracture to ensure interventions were in place to prevent further fall related injuries for Resident #108, who was identified upon readmission as having a high risk for more falls.

The care plan problem read; at risk for fall related injury as evidenced by a previous fall, Alzheimer's Dementia fractured "right" hip, a normal progression of disease process with unavoidable and/or predictable decline. Use of a rolling walker and non-compliance with requesting assistance with transfers. The goal read; the resident will not sustain a fall related injury by utilizing fall precautions through the next review date. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 54	F 657		

interventions were; use fall risk screen to identify risk factors on admission and quarterly. Report falls to physician and responsible party. Observe for side effects of any drug that can cause gait disturbances, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness and change in mental status. Report to the physician any side effects associated with the resident's medication use. Provide environmental adaptations; low platform bed, call light within reach, adequate glare free lighting, and keep area free of clutter. Observe use of walker/cane. Lock brakes on bed, chair, etc. before transferring. When arising sit on the side of the bed before transferring/standing. Educate/remind resident to request assistance prior to ambulation. Appropriate footwear. Weight bearing as tolerated to "right" hip/leg. Invite, encourage, remind, escort to activity programs consistent with resident's interests to enhance physical strengthening needs. Referral for screen physical therapy, mental health, and treatment as needed. Provide resident/family teaching to include safety measures to reduce fall risk. 1/4 side rails as an enabler. Frequent rounds.

An interview was conducted with Licensed Practical Nurse (LPN) #3 on 7/12/18, at approximately 12:10 p.m. LPN #3 stated Resident #108 was very confused and combative, paced to the door and back most of the day, repeatedly stated she wanted to leave the facility, and she often spoke in Spanish but understood English. LPN #3 also stated the resident walked with assistance of a walker because of balance problems.

Also during the interview with LPN #3 she stated the investigation of the fall didn't reveal the last time the resident was observed prior to the fall,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 55 what the resident was doing prior to the fall, if the resident was in a low bed, were fall mats in use or if non-skid socks were in use, or if the resident had eliminated in an inappropriate place resulting in a slip/fall. She was certain no alarms were in use because they are not used by the facility. The incident report, neither the fall investigation report stated the resident was wearing or had remove the non-skid sock or if the bed was in its lowest position at the time of the fall. The care plan indicated Resident #108 was capable of making good decision when she wasn't due to her long and short term memory problems as well as severely impaired daily decision making . Most of the above interventions are standard interventions for all residents not interventions specific to Resident #108. LPN #3 stated the resident didn't have the cognitive ability to institute the above interventions and the questions asked during the fall investigation were not used to develop new care plan interventions. On 7/12/18, at approximately 2:30 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity to present additional information was offered but none was provided. The Director of Nursing stated; the Unit Manager follows up on falls and they discuss all falls in the morning meeting, determine a root cause of the fall, develop interventions and update the person-centered care plan based on the information reviewed. The Director of Nursing further stated, "it doesn't look like we reviewed the fall and updated the care plan thoroughly".	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 56 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility documentation, the facility staff failed to prevent and identify in a timely manner, a pressure ulcer for 1 of 38 residents in the survey sample, Resident #108, resulting in harm. The facility staff failed to identify Resident #108 had developed a sacral pressure ulcer until it had advanced to a stage 3; measuring 6 centimeters by 4 centimeters by 0.1 centimeters, with dark pink tissue, slough, and right side rolled edges with maceration, which constitutes harm. The findings included: Resident #108 was originally admitted to the facility 4/23/18 and readmitted 5/24/18 from a local acute care hospital, after repair of a hip fracture. The current diagnoses included; a left hip fracture, advanced dementia and an anxiety disorder.	F 686	A.With respect to the Specific Residents Cited: Resident #108 no longer resides at the facility. B.With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding providing skin integrity assessments and services as ordered. A skin sweep of residents was done on 7/2 & 3 /18, 8/4-6/18 and any issues identified were immediately addressed, with MD/RP notified, MD orders noted and care plan updated as applicable. New or worsening wounds must be documented on evaluation sheet,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 57 The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making. In section "D" (Mood) the resident is coded for a poor appetite. In section "E" (Behavior), Resident #108 is coded for verbal aggression which significantly interferes care, activities and socialization as well as rejection of care 1-3 days each week. In section "G" (Physical functioning) the resident was coded as requiring total care of 1 with off unit locomotion, personal hygiene and bathing, extensive assistance of 2 people with bed mobility, transfers, dressing, and toileting. She requires extensive assistance of 1 person with on unit locomotion, and supervision after set-up with eating. In section "M" (Skin Conditions) the resident was coded as at risk for pressure ulcer development but without any unhealed pressure ulcers at stage 1 or greater. The Braden Scale for Predicting Pressure Score Risk; revealed Resident #108 was assessed 5/24/18 and score 13, which means Resident #108 had a moderate risk for pressure ulcer development. The weekly skin integrity evaluation revealed as follows: 5/26/18, the resident had impaired skin to the anterior left trochanter (upper lateral thigh) and left upper leg, 5/30/18, impaired skin to the anterior left trochanter and left upper leg, 6/6/18, a posterior skin condition was observed, site not specified. There was no further documentation or	F 686	nurse's notes, 24-hour report and entered into Event Manager and discussed at morning clinical meeting and weekly At-Risk meeting. Audits of wound care practices, including nursing staff competencies, accuracy and completeness of assessments, skin treatments and documentation of care by facility nurses was initiated on 07/13/18 will be completed by 08/8/18 by the SDC, Wound Nurse and DON/designee. C.With Respect to What Systemic Measures have been put in place to address the Stated Concern. By 08/08/18, licensed staff including the nurse managers, will be re-educated by the Wound Nurse and SDC or designee on providing skin integrity assessments and wound care services per physician order and the resident's plan of care, including accurately completing admission and scheduled skin assessments, measurements and photos of wounds, as per facility policies, procedures and standards for the provision of treatments as prescribed and using good infection control practices. The skin assessment competency checklist will be utilized. SDC or designee will complete competencies for C.N.A's on skin reviews during showers/bathing. Aides will perform bathing per schedule, note and skin integrity issues and report any issues (including refusals) to the nurse or unit manager (UM). Nurses were re-educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 58 description of the impaired skin integrity on the above dates. On 7/12/18 at approximately 10:50 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #6 who made the observation of the wound. LPN #6, stated she made the initial observation but LPN #3 followed up and completed the initial assessment. It was explained that LPN #6 was not allowed to assess wounds. Only the Unit Managers and the Wound care nurse are allowed to assess and stage pressure ulcers in the facility. LPN #3 is the UM. On 7/12/18, at approximately 11:00 a.m., an interview was conducted with LPN #3. LPN #3 stated she made the follow-up assessment and referred the surveyor to the Pressure Ulcer Record dated 6/6/18. The record revealed the resident had a stage 3 pressure ulcer to the sacrum, measuring 6 centimeters by 4 centimeters by 0.1 centimeters, and with dark pink tissue, slough, and right side rolled edges with maceration. During the interview with LPN #3, the nurse stated Resident #108 is often confused and combative but; 2 staff members are capable of rendering necessary care. LPN #3 further stated, because of Resident #108 behaviors (hitting, spitting and kicking) the facility staff assigns the same staff to the resident whenever possible to achieve a reduction in the exhibited behaviors. A Physician's order dated 6/7/18 read; Santyl ointment; cleanse wound to the sacrum with normal saline, pat dry, apply a nickel thick layer of Santyl and cover with a dry dressing daily for diagnosis of sacral wound.	F 686	on the requirement to properly document care provided, including how to correctly document Electronic Medical Record (EMAR) and document issues on the 24 hour report and so they may be discussed in the morning meeting. The SDC or designee will observe wound care practices of clinical staff weekdays, using the skin assessment competency checklist and document issues for 12 weeks. The Nursing Management team and Wound Nurse will perform observation audits using the wound care competency checklist to ensure that wound care is being done per physician order, using proper infection control practices and properly documented daily x 12 weeks. D.With Respect to How the Plan of Corrective Measures will be monitored: DON to audit compliance in morning clinical meeting using the DON Morning Meeting Audit Review tool. Issues will be immediately addressed and corrected as necessary. The DON reviews the results of the audits in conjunction with the QAPI committee members. Reported concerns will have interventions developed and appropriate actions taken by the ADM in conjunction with the QAPI Committee members. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 59	F 686		

The Wound Care physician's initial assessment conducted 6/12/18, revealed Resident #108's pressure ulcer measured 2.5 centimeters by 2.0 centimeters by 0.2 centimeters with a moderate amount of sero-sanguinous exudate, 40% thick adherent necrotic tissue and 60% granulation tissue. The Wound Care physician's 6/12/18, note further stated surgical excisional debridement was completed with removal of devitalized tissue, subcutaneous fat and surrounding connective tissue to a depth of 0.3 cm and healthy bleeding tissue was observed.

Resident's #108's wound care was observed on 7/13/18 at approximately 11:55 a.m. Resident #108 was very restless but easily redirected by the Certified Nursing Assistant (CNA) accompanying the RN wound care nurse. She reclined on a low air loss bed covered with a draw sheet. The resident wore a Prevalon boot to the left foot only. A small amount of light yellow drainage was observed to old dressing removed from the pressure ulcer. The sacral pressure ulcer measured approximately 1.5 centimeter (length) by 1.5 centimeters (width) by 0.2 centimeters (depth). The pressure ulcer contained a pale pink bed, and the surrounding tissue was without swelling or redness. The resident didn't complain of or show signs of pain during the procedure.

There was a care plan in use prior to development of the pressure ulcer. The problem was dated 5/2/18, updated 5/10/18 and updated again 6/12/18. It read Resident is at risk for developing skin breakdown. Needs extensive assist with bed mobility and incontinence secondary to the left hip fracture. The goal dated 5/3/18 and updated 5/18/18 read; Resident will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 60	F 686		

have intact skin, free of redness, blisters, or discoloration over boney prominences through the next review date. The interventions read; Report changes in skin status (ie., signs/symptoms of infection, non-healing, new areas) to the physician. Provide diet as ordered and monitor nutritional status and dietary needs; consult Registered Dietitian as needed. Provide pressure relieving or reduction mattress. Complete weekly skin check. Complete Braden Scale Risk Assessment quarterly and as needed. Notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bathing or daily care. Provide incontinence care after incontinence episodes, apply barrier cream as needed.

The active care plan dated 6/12/18 read; problem, Resident has a pressure ulcer Stage 3. The goals read; Pressure ulcer will exhibit signs of healing evidenced by decreased size, improved appearance and be free from signs and symptoms of infection by the next 90 days. Resident will not develop any new areas of skin breakdown through next review date. The interventions were; Report changes in skin status (i.e.; signs/symptoms of infection, non healing, new areas) to physician. Discuss non-compliance issues with resident and responsible party. Educate resident/responsible party about pressure ulcer etiology, primary risk factors, treatment, prevention. Observe laboratory/diagnostics as ordered and report results to the physician. Observe effectiveness of response to treatments as ordered. Consult PT for cushion to the wheel chair, Nutritional consult, Wound care specialist consult. Complete weekly skin checks. Complete Braden Scale Risk Assessment quarterly and as needed. Notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 61	F 686		

nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care. Provide diet as ordered and observe nutritional status and dietary needs; consult dietitian as needed. Assist resident as needed to position/shift weight to relieve pressure. Provide pressure reduction mattress (STAT 2/a low air loss bed). Position with pillows to maintain proper body alignment as needed. Float heels in bed. Provide incontinence care after incontinence episodes; apply barrier cream as needed. Avoid skin to skin contact. Minimize pressure over bony prominence's. Use a lifting device/draw sheet to reduce friction. Wound care as ordered by physician. Provide supplemental protein, amino acids, vitamins, minerals as ordered by physician to promote wound healing. Notify resident/responsible party of any new areas of skin breakdown. Observe for pain and medicate as needed per physician's order.

The facility's undated Pressure Ulcer Risk Assessment document read; the purpose of this procedure is to provide guidelines for assessment and identification of residents at risk for developing pressure ulcer.

Risk Assessment- A pressure ulcer risk assessment will be completed upon admission, and then weekly x 1, with significant changes, and quarterly.

Skin Assessment- Skin will be assessed for the presence of developing pressure ulcer on a weekly basis or more frequently if indicated.

Monitoring- Staff will perform routine skin inspections (with daily care). Nurses are to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 62	F 686		

notified to inspect the skin if skin changes are identified. Nurses will conduct skin assessments at least weekly to identify changes.

On 7/13/18, at approximately 2:30 p.m.,the above findings were shared with the Administrator and Director of Nursing. The Administrator and Director of Nursing acknowledged the stage 3 pressure ulcer and the Administrator stated, "now we have a new Wound Care Nurse".

Definitions:

A Stage 3 pressure ulcer according to the Resident Assessment Instrument Manual (RAI) is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. (RAI Manual, October 2017, Page M-12)

Slough tissue is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. (RAI Manual, October 2017, Page M-18)

Removal of dead or infected tissue from a wound. Debridement can be done with enzymes; mechanically, such as in a whirlpool; or through surgery. (https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=debridment&commit=Search)

Santyl Ointment is indicated for debriding chronic dermal ulcers and severely burned areas. (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 63 m?setid=6b6fbfc6-98fa-46aa-88ef-ab00fbb08ffd) A Prevalon boot offloaded pressure even when the patient is moving. http://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037/	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews and review of facility documentation, the facility staff failed to ensure 2 of 38 residents (#9 and # 25) in the survey sample were free of accident hazards 1. The facility staff failed to ensure Resident #9 was free of accident hazards due to the resident sustaining second degree burns to the upper chest from hot liquids (a cup of noodle soup), which constituted harm for this resident. 2. The facility staff failed to maintain an environment free from accident hazards for one resident (#25) in the survey sample when she ingested paint left accessible to her by a contracted painting company. The findings include:	F 689	A.With respect to the Specific Residents Cited: For resident #9, the resident was treated for the spill immediately by the nursing staff and the physician was notified. Silvadene cream was ordered as the treatment and then was changed to Xeroform dressing due to resident's allergy to Sulfa. Afterwards, the wound care physician added Santyl to the wound treatment. The wound nurse indicated the burn healed as of 12/27/17. Other corrective actions for resident#9 included assessing her ability to feed herself, assisting her as needed, positioning her as needed or requested, removing all microwaves from resident care areas and re-educating staff on facility policy and	8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 64 1. Resident #9 was admitted to the nursing facility on 4/4/14 with diagnoses that included muscle weakness and severe morbid obesity. The most recent Minimum Data Set (MDS) assessment was an Annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible 15 which indicated she was intact with the cognitive skills for daily decision making. The resident was assessed to require set-up help for eating. She was coded to require extensive assistance form two staff for bed mobility, toilet use and bathing. The resident was assessed to require extensive assistance from one staff for dressing and personal hygiene. The assessment coded the resident as mostly bed bound and transferred from bed to wheel chair and back once or twice during the seven day assessment period. The care plan dated 12/2/17 identified a burn to the skin. The goal set by the staff for the resident was that she would have signs of healing. Some of the approaches the staff would use included encouraging the resident to allow staff to rise head of bed during meals, garment protector during meals, weekly documented skin check and follow the physician's orders for skin care and treatments. A facility reported incident (FRI) dated 12/1/17 indicated Resident #9 tipped a cup of noodles from soup onto her upper bare chest and sustained *second-degree burns. The physician was notified and *Silvadene cream was ordered as the treatment. Review of clinical record revealed on 12/2/17 the	F 689	procedures for heating/re-heating food and hot liquids, including the requirement that only kitchen staff or charge nurse(if kitchen staff are not available) may heat/re-heat food or liquids. The container Resident #25 picked up was immediately discarded. She was then sent to the ER for assessment, but she was returned shortly with no harm identified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding resident environment remains free of accidents and hazards. Audits to identify hazards in resident accessible areas was done by the Maintenance staff on 3/26/18. Any issues identified were corrected. Microwaves from all patient care floors were removed. Other corrective actions for other residents that have the potential to be affected by the alleged deficient practice included identifying like residents and assessing them for ability to consume heated foods/liquids need for position or adaptive devices. Any issues or needs were addressed. Other actions include re-educating staff on facility policy and procedures for heating/re-heating food and hot liquids, including the requirement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 65 area was assessed by the Director of Nursing (DON) to be 7 centimeters (cm) by (x) 6 cm with no measurable depth at 0 cm with a 2 cm x 2 cm fluid filled blister at the superior aspects of the burn area. It was recorded that the wound base in the upper region of the burn exhibited the formation of yellow *slough, and the lower portion of the burn was bright red. The treatment regimen was changed to *Xeroform dressing due to resident's allergy to Sulfa. The wound care physician added *Santyl to the wound. The nurse's notes indicated the burn healed as of 12/27/17. On 7/12/18 at 2:00 p.m., an interview was conducted with the Administrator and the DON about the aforementioned incident. He stated that he had instituted a plan for all staff to reheat hot liquids in the microwave that included acquiring the temperature of all reheated foods, and to serve hot liquids (i.e., coffee, soup, tea, etc..) at 140-150 degrees and record in logbook. He stated, when he interviewed the Certified Nursing Assistant that prepared the soup for Resident #9, she stated she heated the water in the microwave and poured it into the prepackaged noodles and let it sit for a few minutes and delivered it to the resident. He stated the CNA admitted to him she did not follow the hot liquid protocol and acquire the temperature of the soup prior to delivering it to the resident. The Administrator stated he removed all microwaves from the nursing units and require the staff to have food and liquids reheated, temped and recorded by the kitchen staff prior to delivering the food item or liquids to residents. On 7/13/18 at 11:00 a.m., an interview was conducted with Resident #9. She stated she was	F 689	that only kitchen staff or charge nurse(if kitchen staff are not available) may heat/re-heat food or liquids. C.With Respect to What Systemic Measures have been put in place to address the Stated Concern. From 12/01/17 through 08/08/18, the ADM or designee re-educated facility staff the requirement that only kitchen staff could reheat hot liquids in the microwave and the kitchen staff would measure the temperature of all reheated foods, and to serve hot liquids (i.e., coffee, soup, tea, etc.) and record temp in temp logbook. Newly hired staff will receive this education through the orientation process and at least annually. From 07/14/18 through 08/08/18, the SDC or designee will re-educate facility staff on facility P&P□s for storing and handling any materials that may be considered hazardous, including paint, medications, creams, salves, cleaning supplies, etc. and to ensure all areas are free of any safety hazards. The director of housekeeping (DHK) will re-educate housekeeping staff on hazardous material storage and handling. Contractors will be educated on the risk of leaving supplies accessible to residents and the requirement to not leave any supplies when leaving the facility. Newly hired staff will receive this education through the orientation process and at least annually. UM□s and Department	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 66 not up in the bed when the CNA gave her the noodle soup, sat it on her over-bed table, after which the resident stated she retrieved the cup and tipped it over onto her chest, but there was mostly noodles that spilled onto her chest than liquid. She stated if she eats or drinks hot liquids she wears a drape (apron) to protect her chest because "I hate anything up against my neck and my upper chest will always be exposed." The resident was observed in bed with the head on the bed at approximately 45 degrees. The area mid-chest exhibited scarring where the burn had once been. *Silvadene Cream 1% (silver sulfadiazine) is a topical antimicrobial drug indicated as an adjunct for the prevention and treatment of wound sepsis in patients with second- and third-degree burns (https://www.pfizermedicalinformation.com/en-us/silvadene-cream). *Second degree burns involve the first two layers of skin with signs of deep reddening of the skin, pain, blisters and glossy appearance from leaking fluid with loss of skin (https://www.cdc.gov/masstrauma/factsheets/public/burns.pdf). *Xeroform dressing is a fine mesh gauze impregnated with aqueous solutions that contain antimicrobial agents to control bacterial growth and to maintain a moist environment at the wound surface which is excellent for the treatment of burns and skin grafts (https://www.ncbi.nlm.nih.gov/pubmed/8537426). *Santyl (Collagenase) This product is used to help the healing of burns and skin ulcers. Collagenase is an enzyme. It works by helping to	F 689	Heads/Ambassadors will audit resident rooms, day rooms, halls and dining areas for hazardous materials or other safety hazards at least once each workday during their assigned Ambassador Rounds per facility policy and procedure. Issues will be immediately corrected. IDT members will review of issues in Morning stand-up meeting and the ADM will document on the Daily Worksheet. D.With Respect to How the Plan of Corrective Measures will be monitored: ADM/designee will audit compliance with the IDT members in morning meeting using the Daily Worksheet. Issues will be immediately addressed and corrected as necessary. ADM or designee will review audits and report findings at monthly QAPI meeting for resolution. The ADM/DON reviews the results of the audit in conjunction with the QAPI committee members or designated subcommittee. Reported concerns will have interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee members. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee members will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 67	F 689		

break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (http://www.webmd.com/drugs/2/drug-9489/santyl-topical/details).

2. Resident #25 was admitted to the facility on 8/23/17 with diagnoses that include but are not limited to Alzheimer's disease, difficulty walking, major depressive disorder, muscle weakness, and chronic pain.

The facility staff failed to maintain an environment free from accident hazards for Resident #25 when she ingested paint left accessible to her by a contracted painting company.

A care plan was developed and revised for Resident #25 on 11/13/17 and revised on 5/11/18 which included, Problem, Need, Strength, and Potential Concerns: "Behavior problems-impulsiveness, getting up from wheel chair without assistance, sitting on the floor, putting inedible objects into mouth. Goal: Resident will not harm themselves or others secondary to their behavior through the next review date. Approach: Report to physician changes in behavioral status, Reinforce positive behaviors, Observe behavior episodes and attempt to determine underlying cause, Observe and assure surroundings are safe (ie: all inedible objects ie: creams). Jars, etc. have tops and are closed properly, Monitor frequently for safety".

A quarterly MDS 3.0 (Minimum Data Set) was composed for Resident #25 on the ARD (Assessment Reference Date) of 1/19/18 which included a BIMS (Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 68	F 689		

Status) score of 6 indicating severely impaired cognition. Resident #25's ADL (Activities of Daily Living) status was listed as needing extensive assistance for self-performance in the areas of bed mobility, transfers, dressing, toilet use and personal hygiene and needing the assistance of 1 facility staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #25 needed supervision for walking and eating and set up only assistance from staff for eating.

An annual MDS 3.0 (Minimum Data Set) was composed for Resident #25 on the ARD of 4/20/18 which included a BIMS score of 6 indicating severely impaired cognition. Resident #25's ADL status was listed as needing extensive assistance for self-performance in the areas of bed mobility, transfers, dressing, toilet use and personal hygiene and needing the assistance of 1 facility staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #25 needed set up only assistance from staff for eating, and walked without staff assistance.

Review of facility documentation dated 3/26/18 noted Resident #25 "put some latex paint from a cup the contractor was using to patch a wall in her mouth. She spit it out and was sent to the ER for evaluation, no vomiting, no respiratory symptoms returned from the ER. Paint and all contracting supplies removed from the resident area. Contractor will take all supplies with them when they leave."

On 7/10/18 at 10:45 AM Observed pleasantly confused, non-interview able resident sitting on the couch in the hallway with another resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69	F 689		

She appears well groomed and clean. Observation conducted in all rooms and noted no inedible products in the resident areas.

On 7/11/18 at 10:16 AM attempted again to interview Resident #25 and noted her as very confused.

On 7/11/18 at 10:20 AM an interview was conducted with LPN # 6 who stated the secure unit was being renovated and a contractor had been painting on the unit. The activities department was serving milk shakes that afternoon for the residents. The resident poured some latex paint into a cup and "took a sip and spit it out." The contractor "was done for the day."

On 7/12/18 at 9:50 AM an interview with the Administrator was conducted. He stated the "contractor was done with the job that day and took all the supplies with them". When asked if more should have been done to prevent the resident accidental exposure to the hazard, he stated "yes". The administrator was asked if there had been any education provided to the contractor about the risks associated with the resident population on a secured unit he stated "there was no education provided [to the contractor] before or after the incident." The administrator agreed "residents could be at risk from hazards in the environment" on the secured unit.

A review of the report from the emergency room visit on 3/25/18 at 7:50 PM noted the resident "with dementia from [facility name] was sent in because they were worried she [Resident # 25] had consumed, [paint] dried white material was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 70 around her mouth and on her gums. No vomiting and no respiratory symptoms. Very pleasant demented so cannot answer any specific questions." "D/C [discharge] to nursing home." A document review of the Safety Data Sheet (Required information for hazardous products by the Occupational Safety and Health Administration) for ProMar 400 Zero VOC Interior latex paint Eg-Shel (paint consumed) noted in part: Ingestion: "Wash out mouth with water. Remove dentures if any. If material has been swallowed give small quantities of water. Stop if exposed person feels sick as vomiting may be dangerous. Do not induce vomiting. No Known significant or critical hazards". The facility staff failed to maintain an environment free from accident hazards for Resident #25 when she ingested paint left accessible to her by a contracted painting company.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		8/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 71 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to ensure drugs and biological were secured and stored and discarded per professional guidelines. 1. The facility staff failed to discard 3 expired Culture Swab Collection and Transport System tubes that were located in the medication room on Unit 2. 2. The facility staff failed to discard an expired Lantus insulin located in the medication cart on Unit 2 (Long hall medication cart). 3. The facility staff failed to ensure a medication cart was locked when not in direct site of the nurse for 1 of 3 units (Unit 3). 4. The facility staff failed to assure medications were secure and inaccessible to Resident #139 who ingested anti-fungal ointment. 5. The facility staff failed to ensure that 3 medications supplied by the Resident #13's family	F 761	A.With respect to the Specific Residents Cited: The medications accessible to Residents #139 and #13 were removed at the time of notification by surveyor(s). The expired insulin and lab supplies were appropriately discarded by the unit manager immediately after notification for the surveyor(s). The DON and UM's verified medications carts were locked after notification. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents receiving medications have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding labeling and storing drugs and biologicals. Audits of all medication carts for proper storage was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 72	F 761		

were stored appropriately and not left at the resident's bedside.

The findings include:

1. On 07/11/18 at approximately 8:15 a.m., the Medication Storage Room on Unit 3 was inspected with Unit Manager - License Practical Nurse (LPN) #2. Inside the medication room were three (3) Culture Swab Collection and transport system tubes with an expiration date of January 2018. The surveyor handed the culture swab tubes Unit Manager who stated, "They expired in January 2018." The surveyor asked, "Should the culture swab tubes be in your medication storage room, she replied, "No ma'am - I'm moving it right now." The surveyor asked, "Who is responsible to ensure expired biological are removed from the med storage room" she replied, "All nurses are responsible actually."

An interview was conducted with Director of Nursing (DON) on at 7/11/18 at approximately 12:20 p.m., who stated, "The Unit Manager is to inspect the medication room for expired biologicals."

2. On 07/11/18 at approximately 2:30 p.m., the medication cart on Unit 2 was inspected with License Practical Nurse (LPN) #1. Inside the medication cart was a multi dose vial of Lantus Insulin with an open date of 06/08/18. The surveyor asked, "Has the Lantus stored on the medication cart with an open date of 06/08/18 expired and she replied "Yes." The surveyor asked LPN #1 how long is Lantus good for once open, she replied "30 days." LPN stated, "The Lantus insulin should have been taken off the cart, I will remove now." The LPN removed the

performed by the unit mangers on 07/12/18. Any issues identified were corrected. Audits to identify hazards in resident accessible areas was done by the maintenance staff and department heads on 07/12/18. Any issues identified were corrected.

C.With Respect to What Systemic Measures have been put in place to address the Stated Concern.

From 07/14/18 through 08/08/18, the SDC or designee will re-educate nursing staff on facility policies, procedures and standards for medication storage, including expired medications and lab supplies storage, meds at bedside, checking the expiration dates on all medications at least twice prior to use, locking medication carts when unattended and not storing internal and external medications together. Newly hired nursing staff will receive this education through the orientation process and at least annually.
From 07/14/18 through 08/8/18, the SDC will re-educate facility staff on the need to continually audit all areas to ensure residents may not access drugs or biologicals, hazardous materials or other safety hazards. Newly hired staff will receive this education through the orientation process and at least annually.

The SDC will audit at least 2 nurses for medication administration and storage competencies weekly using the medication competencies checklist. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 73 open vial of Lantus with an open date of 06/08/18 off the medication cart. The surveyor asked, "Who is responsible for making sure expired insulin's are removed from the medication cart, she replied, "Who ever gives the medication." An interview was conducted with Director of Nursing (DON) on at 7/11/18 at approximately 12:20 p.m., who stated, "The insulin should not have been there." The DON then said the nurses should check the medications before med pass for expiration dates on each shift." *Lantus is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It 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). The manufactures recommendation on how to store Lantus: -The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it. 3. On 07/11/18 at approximately 9:42 a.m., the medication cart on unit 3 was unlocked and left unattended when not in direct site of the nurse. Three staff members walked past the medication cart while unlocked and unsupervised. LPN #2 came out of a resident room saying, "I forgot to lock my medication cart, I can't believe I did that." The surveyor asked, "How did you know your cart was unlocked, she replied, "Someone came in and told me." While this surveyor was standing	F 761	UM/designee will audit carts/med rooms 2 times weekly for 12 weeks and will also review medication storage compliance audits using the medication storage audit tool each weekday for 12 weeks, then weekly times one month. Pharmacy Consultant or designee will monitor through quarterly med pass reviews and evaluate medication carts for outdated medications and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary. UM's and Department Heads/Ambassadors will audit resident rooms, day rooms, halls and dining areas for hazardous materials or other safety hazards at least once each workday during their assigned Ambassador Rounds per facility policy and procedure. The Manager on Duty (MOD) will audit on weekends using the MOD duty sheet. Issues will be immediately corrected. IDT members will review of issues in Morning stand-up meeting and the ADM will document on the Daily Worksheet. D.With Respect to How the Plan of Corrective Measures will be monitored: DON/designee will audit compliance with clinical IDT members in morning meeting. Pharmacy Consultant or designee will monitor monthly thru monthly med pass reviews and evaluate medication carts for outdated medications and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 74 at the medication unlocked; there were 2 staff members who walked past the medication cart while unlock and unsupervised by the nurse. An interview was conducted with Social Worker (SW) on 07/11/18 at approximately 9:50 a.m. The SW said she was in the hallway and noticed that LPN #1 had left her medication cart unlocked so I went and told her. An interview was conducted with Director of Nursing (DON) on at 7/11/18 at approximately 12:20 p.m., who stated, "The medication cart should be locked when in not in the nurses view." The facility Administrator was informed of the findings during a briefing on 7/12/18 at approximately 2:40 p.m. The facility did not present any further information about the findings. The facility policy titled Storage of Medication - Section 4.1 (Revision 2007). Policy: Medications and biologicals are stored properly, following manufacture's or provide pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures to read in part: -In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication	F 761	necessary. DON or designee will review audits and report findings at monthly QAPI meeting for resolution. The ADM/DON reviews the results of the audit in conjunction with the QAPI committee members or designated subcommittee. Reported concerns will have interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee members. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee members will develop alternate interventions until compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 75	F 761		

rooms, cabinets and medication supplies should remain locked when not is use or attended by personals with authorized access.

4. The facility staff failed to assure medications were secure and inaccessible to one Resident (#139) who ingested anti-fungal ointment.

Resident #139 was admitted to the facility on 3/20/18 with diagnoses that include but are not limited to altered mental status unspecified, fungal infection on the buttocks, muscle weakness, and spinal stenosis (narrowing on the spinal canal). Resident #139 was discharged into the community on 4/24/18.

The facility staff failed to assure medications were secure and inaccessible to Resident #139 who ingested anti-fungal ointment left on her over bed table.

An admission MDS 3.0 (Minimum Data Set) was completed for Resident #139 on the ARD (Assessment Reference Date) of 3/27/18, which included a BIMS (Brief Interview for Mental Status) score of 6 indicating severely impaired cognition. Resident #139's ADL (Activities of Daily Living) status was listed as totally dependent for self-performance in the areas transfers, dressing, and toilet use, needing extensive assistance of bed mobility, eating, and hygiene. She needed the assistance of 2 facility staff member for bed mobility, transfers, and toileting, and assistance of 1 staff member for dressing, eating, and hygiene. Resident #139 did not walk.

A care plan was developed and revised for Resident #139 on 3/30/18 which included Problem, Resident has ADL (activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 76	F 761		

living) self-care deficit, and is at risk for complications, resident needs assist with transfers, toileting, grooming, locomotion, and dressing, Goal: Resident will be clean groomed, and dressed by staff daily throughout the next review. Approach: Refer to therapy as needed, Staff to assist with ADL's, "Resident educated on tasting things left on bedside table and asked to call nurse if anything in med cups left in reach. Resident states she understood and would not have normally done that."

Review of facility documentation dated 4/12/18 noted Resident #139 stated she "ingested some ointment that was in a med cup on her over bed table less than 10ml [milliliters]". "Called pharmacy and poison control / nontoxic. Resident [#139] sent to the ER as a precaution. She was sent back with no adverse effects to resident. Action plan developed/implemented. All rooms checked for medications/hazardous material and no issues identified. Staff to be in re-educated on storage of medications and hazardous material."

A review of the emergency room report dated 4/12/18 noted "Today nurse report that she [Resident #139] accidentally ate barrier cream (bamex/nystatin). Upon assessment, she denies any issues. Pharmacy was called and report there shouldn't be any harm to patient. Discussed with unit manager, her [Resident #139] son is adamant that patient goes out 911 to ER for eval [evaluation]." Resident #139 stated "I thought it was cream cheese". Resident was returned to the facility.

A review of Resident # 139's medication orders included Nystatin Triamcinolone cream

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 77	F 761		

(anti-fungal)-apply to peri area (genital area) and buttocks after each incontinent episode.

On 7/12/18 at 10:00 AM an interview with the Administrator was conducted and the incident was reviewed. He stated the medication was non-toxic and Resident #139 had applied it to her lips, but "should not have been left at the resident's bedside". He stated further that "staff has been in serviced on medication storage".

Facility policy titled 4.1 Storage of Medication issued 11/17 stated in part:
Medications and biologicals are stored properly. Medication supply shall be accessible only to licensed nursing personnel, or staff members authorized to administer medications.

A review of the facility policy for Medication Administration Section 7.1 and dated 05/16 in part stated:
Medication Administration:
4. Medications are to be administered at the time they are prepared.
15. Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care centers Interdisciplinary Team (IDT) and in accordance with procedures for self-administration of medications and state regulations.

The facility staff failed to assure medications were secure and inaccessible to Resident #139 who ingested anti-fungal ointment left on her over bed table.
5. The facility staff failed to ensure that 3 medications supplied by the Resident #13's family were stored appropriately and not left at the resident's bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 78	F 761		

Resident #13 was a 59 year old admitted to the facility on 4/4/17 with diagnoses to include (1.) End Stage Renal Disease and Depression.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 7/6/18. Under Section C, Cognitive Patterns Resident #13 was coded to be modified independent in cognitive skills for daily decision making.

Resident #13's Comprehensive Care Plan last revised 6/21/18 was reviewed and is documented in part, as follows:

Problem:
Potential for complications related to hemodialysis, ERSD (end stage renal disease) dialysis Tuesday-Thursday-Saturday.

Approach:
Nursing to apply Lidocaine gel to extremity, dialysis access 30 minutes prior to dialysis.

On 07/09/18 8:38 PM surveyor entered resident's room for initial greeting. Resident #13 was observed sitting up on side of bed watching television. He was alert and oriented, told surveyor about his parents and that he goes to dialysis. Noted a yellowish box on the resident's bedside table with a tube of Lidocaine 5% Anorectal Cream from Pharmacy (Name) dated 6/25/18, a spray can of Pain Ease Medium Strength Aerosol from Pharmacy (Name) dated 6/26/18, and one tube of Triple Antibiotic Ointment 1 ounce. Resident was asked about the 3 medications at his bedside and he stated, "Yes they are mine and I use then 30 minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 79	F 761		

before dialysis on my arm. My mom got it for me." The surveyor asked if the nurses' apply the medications or if he does and if they are always at his bedside. The Resident stated, "They do it at dialysis and its always with me, I keep it."

On 07/10/18 11:30 AM a box with a tube of Lidocaine 5% Anorectal Cream from the Pharmacy dated 6/25/18 and a spray can of Pain Ease Medium Strength Aerosol 3.5 fluid ounces from the Pharmacy dated 6/26/18, and one tube of Triple Antibiotic Ointment 1 ounce remains at the resident's bedside.

On 07/11/18 02:12 PM a box with a tube of Lidocaine 5% Anorectal Cream from the Pharmacy dated 6/25/18 and a spray can of Pain Ease Medium Strength Aerosol 3.5 fluid ounces from the Pharmacy dated 6/26/18, and one tube of Triple Antibiotic Ointment 1 ounce remains at the resident's bedside.

On 07/12/18 02:12 PM a box with tube of Lidocaine 5% Anorectal Cream from the Pharmacy dated 6/25/18 and a spray can of Pain Ease Medium Strength Aerosol 3.5 fluid ounces from the Pharmacy dated 6/26/18, and one tube of Triple Antibiotic Ointment 1 ounce remains at the resident's bedside.

On 07/12/18 2:36 PM An interview was conducted with the Unit Manager Registered Nurse (RN) #2. RN #2 was taken to the resident's room and shown the 3 medications on the resident's bedside table. RN # 2 stated, "He applies those to his arm before he leaves for dialysis." Floor nurse Licensed Practical Nurse (LPN) #8 entered the room who is the regular nurse for the resident. LPN #8 was asked if the 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 80	F 761		

medications on the resident's bedside should been there and if the resident had been assessed to self administer his own medications. LPN #8 stated, "No the medications should not be at his bedside and no he has not been assessed to self administer. These medications are not even from our pharmacy they are from (Name) Pharmacy and this isn't even his doctor in here. I will call his doctor and get it taken care of." RN #2 and LPN #8 were asked why the medications should not be at the bedside. LPN #8 stated, "Because it's a safety reason for the resident and all the other resident's."

On 07/12/18 2:40 PM The above information was shared with the Director of Nursing and she was asked what she would have expected regarding the medications at Resident #13's bedside. The DON stated, "Medications should only be at the bedside with a physician order, the resident should have had a medication self-administration assessment completed, and the care plan should have been updated for the medications at the bedside and self administration if appropriate for that resident."

Resident #13's Progress Noted dated 7/12/18 at 3:35 PM by LPN #8 was reviewed and is documented in part, as follows:

Spoke with Dialysis, Lidocaine spray order given by Doctor Name on 6/23/18 at Dialysis, order was picked up by mother and given to resident. Lidocaine spray D/C (discontinued) at this time per MD (medical doctor) order. Resident to continue current lidocaine ointment per order. Spoke with Resident's mother via phone and educated that resident may not self administer medications and not to bring in medications for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 81	F 761		

resident without nurse's notification. Resident's mother made aware she is to pick up lidocaine spray and triple antibiotic. Resident's mother states that she does not remember why the triple antibiotic was given to resident. MD made aware.

The facility policy titled " Bedside Medication Storage" dated 11/17 was reviewed and is documented in part, as follows:

POLICY:
Bedside medication storage is permitted for resident's who are able to self-administer medications, upon written order of the prescriber and when it is deemed appropriate in the judgement of the nursing care center's interdisciplinary resident assessment team.

5. All nurses and nursing aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary.

On 7/ 13/18 at 11:15 AM a pre-exit conference was conducted with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was shared.

(1). End Stage Renal Disease: a disease condition that is essentially terminal because of irreversible damage to vital tissue or organs. Kidney or renal end stage disease is defined as a point at which the kidney is so badly damaged or scarred that dialysis or transplantation is required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 761	Continued From page 82 for patient survival. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 761		