PRINTED: 11/26/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495392	8. WING		11/	14/2019		
NAME OF I	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	1 117	1-42015	
SENTAR	A NURSING AND REF	IAB CENTER-WINDERMERE			DLD DONATION PKWY INIA BEACH, VA 23454			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E	000				
F 000	survey was conduct The facility was in s CFR Part 483.73, R Care Facilities. No complaints were inv	mergency Preparedness ed 11/12/19 through 11/14/19. ubstantial compliance with 42 equirement for Long-Term emergency preparedness restigated during the survey.	FC	00				
	survey was conduct 11/14/2019. Correct compliance with the the Federal Long Te life safety code surv	ledicare/Medicald standard ed from 11/12/2019 through ions are required for following 42 CFR Part 483 of erm Care requirements. The rey/report will follow. No restigated during the survey.						
F 584 SS=D	at the time of the su consisted of 35 curr closed records revie Safe/Clean/Comfort CFR(s): 483.10(i)(1) §483.10(i) Safe Env	able/Homelike Environment)-(7) ironment.	F 5		#27 were repaired prior to survey exiting the building.	team		
S	comfortable and ho	,		3.	are at risk when a sanitary and homelike environment is not maintained. Staff in all departments will be			
	§483.10(i)(1) A safe homelike environme use his or her perso possible. (i) This includes ensureceive care and se	clean, comfortable, and ent, allowing the resident to enal belongings to the extent euring that the resident can rvices safely and that the e facility maximizes resident			educated on completing work ord for equipment that is broken or in of repair.			
ABORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE	

Administrator

(X6) DAT

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		i i		X3) DATE SURVEY COMPLETED	
		495392	B. WING	i		11/	14/2019	
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		16	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454		14/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 584	(ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary and comfortable into §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private resident room, as specified in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initially 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation documentation, the aclean, sanitary and of 38 residents (Resurvey sample. The findings include 1. For Resident #6, observed with worn, pads. Resident #6 very samples.	does not pose a safety risk. exercise reasonable care for resident's property from loss exeeping and maintenance to maintain a sanitary, orderly, erior; bed and bath linens that are e closet space in each pecified in §483.90 (e)(2)(iv); rate and comfortable lighting ortable and safe temperature ally certified after October 1, a temperature range of 71 to e maintenance of comfortable IT is not met as evidenced on, staff interviews and facility facility staff failed to maintain d homelike environment for 2 ident #6 and #27) in the d:	F	584	 Maintenance staff will conduct a 10 audit of all current facility wheelchar to ensure they are clean and in good working order. Maintenance will conduct audits of wheelchairs and mobility equipment once a quarter the ensure equipment is in good working order. Administrator or designee were view completed work order report weekly to ensure broken equipment being reported and repaired. Audit results will be shared with QAPI committee. Date of Completion December 27, 2019 	irs od to ng ill ts		

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495392	B. WING			M Albana	
	VIDER OR SUPPLIER URSING AND REI	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	DE 11	/14/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	, , , , , , , , , , , , , , , , , , , ,	SHOULD BE	COMPLETION DATE	
but dis The ass (AF out Intersection on two ass The (mouse ass The Congress arm on Resisti arm rem the Dire ass pad defi ever rest right.	e current Minimusessment with an RD) of 08/01/19 of to fa possible screwiew for Mental vere cognitive impled Resident #6 e hygiene and bate with bed mobility devices) was code obility devices) was code objected by the proximately 11:33-19 at approximately need to be reinformed maint to needed to need to	ge 2 ementia with behavioral m Data Set (MDS), quarterly Assessment Reference Date coded the resident with a 00 ore of 15 on the Brief Status (BIMS) indicating pairment. In addition, the MDS requiring total dependence of thing, extensive assistance of y and transfer, extensive ith dressing and toilet use. d under section G 0600 as coded for wheel chair facility on 11/12/19 at a.m., Resident #6 was d. Resident #6's wheel chair vorn, torn and cracked eximately 10:09 a.m., served in the day lounge chair. The wheel chair sident #6's wheel chair ; worn, torn and cracked. On proximately 10:34 a.m., the ince with the surveyor present if swheel chair's armrest in arm rest pads most replaced." He said no one enance that Resident's #6's iplaced; I will take care of this eximately 11:00 a.m., ral armrest pads to her	F 5	84			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019	
		IAB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	11/	14/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 584	Director of Nursing 4:25 p.m. The facili information about the 2. For Resident #2: observed with worm pads. Resident #2: on 12/08/17. Diagnincluded but not lime. The current Minimu assessment with an (ARD) of 09/05/19 cout of a possible scillaterview for Mental cognitive Impairment Resident #27 requires one with transfer, dimobility and toilet us extensive assistance. The MDS was code (mobility devices) wu sage. During the initial tou approximately 11:38 in his bed. His whee worn, torn and crack on 11/13/19 at approximately 11:38 in his bed. His whee worn, torn and crack on 11/13/19 at approximately and the same day at app Director of Maintena Resident #27's room	with the Administrator and on 11/14/19 at approximately ity did not present any further le findings. 7, the wheel chair was torn and cracked armrest was admitted to the facility oses for Resident #27 ited to, muscle weakness. m Data Set (MDS), an annual Assessment Reference Date coded the resident with a 15 ore of 15 on the Brief Status (BIMS) indicating no let. In addition, the MDS coded ing extensive assistance of ressing, hygiene, bathing, bed se. The MDS also included the of one on and off the unit. In dunder section G 0600 as coded for wheel chair of the facility on 11/12/19 at a.m., Resident #27 was lying all chair was observed with	F	584				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REI	AB CENTER-WINDERMERE		1604 Q	TADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY NIA BEACH, VA 23454	1 107	142013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 584	they need to be rep plastic is cracked at Certified Nursing As should have put a whave the armrests replace them right ron 11/13/19 at appression of the place them right ron 11/13/19 at appression of the place them right ron 11/13/19 at appression of the place them right ron 11/13/19 at appression of the place them right ron 11/13/19 at appression of the place the resident the resident formation about the resident has the resident has the resident is not lice to the place the resident's ron 11/13/19 at appression of the place the resident's ron 11/13/19 at appression of the place the resident's ron 11/13/19 at appression of the place the resident's ron 11/13/19 at appression of the place the resident's ron 11/13/19 at appression of the place the place the resident's ron 11/13/19 at appression of the place	ds should not look like this, laced." He stated, "The and coming apart." He said the esistant (CNA) or nursing work order in the computer to eplaced and stated "I will now." roximately 1:00 p.m., Resident chair armrests were replaced. with the Administrator and on 11/14/19 at approximately ity did not present any further are findings. Id Neglect I) rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This mited to freedom from at, involuntary seclusion and mical restraint not required to medical symptoms. lity must- se verbal, mental, sexual, or poral punishment, or	F 60		Resident #14 was monitored for a adverse effects from the encounter No adverse outcomes were obserned All residents with cognitive or communication impairment are at from unwanted sexual advances. Staff in all departments will be educated on how to identify different types of abuse to include unwanter sexual advances and the appropriactions to take.	r. ved. risk nt d ate files as	
	and facility documer	view, clinical record review nt review, it was determined ad to ensure one resident			weeks, then monthly x 2 months. Audits will be shared with QAPI committee with revisions to action as needed based on audit results.		

		L III DIO IID OLI IVIOLO				MR NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL(E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_	<u></u>	495392	B. WING			11/	14/2019
SENTAR		HAB CENTER-WINDERMERE		16	TREET ADDRESS, CITY, STATE, ZIP CODE 504 OLD DONATION PKWY IRGINIA BEACH, VA 23454	-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE
F 600	initiated by another occurred on two occurred	s free from a sexual encounter resident (Resident #44) that casions on 8/30/19.	F	600	5. Date of Completion December 27, 2019		
	not limited to demer disturbance and mu #14's most recent M quarterly assessme reference date) of 8 coded as being sev function scoring 01 BIMS (Brief Intervie Resident #14 was of sometimes being un sometimes understa was coded as requi one staff member w	oses that included but were not with behavioral iscle weakness. Resident IDS assessment was a not with an ARD (assessment I/20/19. Resident #14 was erely impaired in cognitive out of possible 15 on the w for Mental Status) exam. oded in Section B as inderstood by staff and anding staff. Resident #14 ring extensive assistance with the bed mobility, and dressing; ce on staff with personal					
	3/23/17 with diagnoral limited to Schizophr disorder, anxiety dis Lewy Bodies (1). Re MDS (minimum data quarterly assessmenterence date) of 9 coded as being intared 15 out of 15 on the Mental Status) examined imited assembler with transfer	dmitted to the facility on ses that included but were not enia, major depressive order and dementia with esident #44's most recent a set) assessment was a nt with an ARD (assessment /30/19. Resident #44 was ct in cognitive function scoring BIMS (Brief Interview for n. Resident #44 was coded as istance with one staff ers, locomotion, dressing, and nd independent with bed					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	ODE		T-WEOT 8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ge 6	F6	600		<u></u>	
45 E94	a nursing note date the following: "At 21 this nurse was grab and brought to a dif this resident (Resid another resident (Re appeared to have a baseline and was gr	#44's clinical record revealed d 8/30/19 that documented 10 (9:10 p.m.) this evening bed by another staff worker ferent resident's room to find ent #44) face down on top of esident #14). Neither resident ny injuries. This resident is at uestioned about what ot answer. Will continue to					
	second incident with documented the foll #44) observed by 2 another resident's n she was sitting in wip.m. When nurse of mouth-was a ten-dobelonged to residen put the money in the answer but was laughtation for close obs	ote dated 8/30/19 revealed a in Resident #14 that lowing: "Resident (Resident staff pushing paper into mouth (Resident #14) while heelchair at bedside 10:30 necked the other resident's ollar bill in her mouth that it. When questioned why she is resident's mouth-would not ghing. Was placed as nurse's servation as was still awake.					
		nce that Resident #44 had of sexual behaviors prior to					
	revealed that the fac	acility reported incident) cility did not submit a FRI to e agencies until 9/4/19. The nented:					
84	"Incident date 9/1/19 reported that resider	9; Report date: 9/3/19: Staff nt (Resident #44) was					

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		495392	B. WING				140010
	PROVIDER OR SUPPLIER A NURSING AND REM	IAB CENTER-WINDERMERE	*	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 600	two occasions and t making sexual adva	ent (Resident #14) room on that she appeared to be ances towards her."	Fé	600)		
90	This fax confirmatio	owing: "9-3-19 4:06 p.m." n revealed that the fax had ne FRI was submitted a					
	Review of witness s documented the following	tatements collected from staff owing:					
	who witnessed incid 9:30 p.m., I saw (Na room of (Name of Re front of (Name of Re up to her knee. Calle me get her up. At 10 went to the room to #14) and I saw (Nam (Resident #14's) bed	collected by CNA (CNA #1) lents: "8/30/19 Friday @ (at) ame of Resident #44) at the esident #14) face down in esident #14) with open brief ed (Name of LPN #3) to help 0:15 p.m. after my rounds I check (Name of Resident ne of Resident #44) sitting in d trying to open (Name of f and money on (Resident					
	Practical Nurse) #3: (approximately) 212: to me and said she if ran down the hall to and find (Resident # legs and her brief ur her chair and helped approximately 2230 as found again in (R brief undone but this dollar bill down her the	collected by LPN (Licensed "8/3019: At approx. 0 (9:20 p.m.) a CNA came up needed my help STAT. So we enter (room of Resident #14) 44) lying on top of residents adone. We assisted her into I her into her room. At (10:30 p.m.). (Resident #44) esident #14's room); again time she was shoving a \$10 hroat. I pulled it out and doing and she just giggled.					

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		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	1	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	(XS) COMPLETION DATE
F 600	monitoring. We aga doing and she state the (sic) started to go nurses station." An email was attack from the LPN #1, the #44 on 8/30/19 to the Operations (not the DON (Director of Nicon 8/31/19 at 4:08 adocumented: "I wan incident -actually 8/30, at 9 p.m staff #44) lying in bed on #14). No apparent in Resident #44) was that 10:30 pm- staff as sitting in her wheeled bed stuffing a 10 do laughing. (Name of and again we took (and kept her with stanurses station or in unsure what to do be doctor's book and I internal incident repof Resident #44 has organization) as #1 confused now & (an residents? Let me key to be done"	brought to nurses station for in asked her what she was d, "She called me in there." piggling again. Will keep at med the witness statements a nurse assigned to Resident are Facility Vice President of facility administrator) and the ursing). The email was written a.m. The following was anted to make you aware of 2 that happened on my shift of found (Name of Resident top of (Name of Resident aluries and (Name of Alaken back to her room. Then gain found (Resident #44) hair besides (Resident #14) liar bill into her mouth while Resident #14) out of the room aff all night-either at the small dining room. I was esides chart incidents, put in did write a STARS (name of orting system) reports. (Name of Name of Healthcare contact- she is more d) maybe dangerous to the now if there is anything else	F	300			

STATEME AND PLAI	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495392	B. WING	·		11/	14/2019
	F PROVIDER OR SUPPLIER RA NURSING AND REI	AAB CENTER-WINDERMERE		STREET ADDRESS, C 1604 OLD DONATIO VIRGINIA BEACH			14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 60	The five-day follow and faxed to the ap 9/6/19. The followin the facility administ administrator) intended regarding event. (Nappeared to have distated she remember that she had followed there. She stated she wheth make sexual advant Resident #14), Resident #14), Resident #44) was towards (Name of Finot substantiated distintent to (Resident #44) does behaviors but has naggressiveness or it admission. This new and the appropriate taken." Review of Resident the physician had evere inappropriate taken." Review of Resident the physician had evere inappropriate taken. The following was called over the had severe inappropriate to the was going into touching them. She ordered some basic to have a urinalysis	ge 9 up to the FRI was completed propriate state agencies on g was documented in part by rator; "This writer (facility riewed (Resident #44) ame of Resident #44) ifficulty with her recall but ered being in the room and ed (Name of Resident #14) he was trying to help her. er she was attempting to ces towards (Name of ident #44 stated that she was bservations of staff and the vents it appears that (Name as making sexual advances desident #14). Sexual abuse is ue to the inability to assign f44's) actions due to her f delusions. (Name of not have a history of ot demonstrated sexual nappropriateness since her or behavior does present a risk follow up action will be #44's clinical record revealed valuated Resident #44 on g in part, was documented: "I weekend because the patient oriate behavior of a sexual as grabbing people (staff) by they were trying to bathe her. other patient's room and remembers none of thiswe labs but the patient refused doneThere would be no incations that account for this	F	500			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY IPLETED
		495392	B. WING _		11/	14/2019
SENTAR	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	1 10	14,2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 600	that her sons appar with her and they blable to callWe had I think that is import not medical. She is Review of Resident that psychiatry service on 9/10/19. The following the psych NP (nu seen today at staff rinvolved in sexually behaviorResident not think the behavior Nobedoy (sic) actually behaviorResident not think the behavior with the sense is not going to had anything to do with the depression (sic) had anything to do with the depression QHS (excited anything to target. Actually for additional treatment have increased. Additional treatment have increased. Additional treatment increased increased. Additional treatment increased	change we can think of is ently stopped communicating ocked her phone from being we asked psychiatry to see her ant. I think this is psychiatric not harmful or suicidal." #44's clinical record revealed ices evaluated Resident #44 owing was documented in partures practitioner): "Patient request. Reason: Resident inappropriate (sic) reprots (sic) she does or was inappropriate. Ally had sex. Reprots (sic) that nurt anyone or do anything to ad. Rewident (sic) reprotsw sic) visual and auditory (sic) visual and auditory (sic) visual and auditory (sic) visual and auditory (sic) reprotsw sic) visual and auditory (sic) reprots (sic) with incidentStaff reports expressed related to lonliness extitons: Perphenazine (2) 2 (schizophrenia BID (two times (3) 30 mg tablet Reason: very night)Assessment/Plan: the treatment currently not did Risperdol (4) 0.25 mg mouth) BID (two times a day) ent. 2. Depression features did Zoloft (5) 50 mg po qd ed to improve restraint for	F 60			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			.,,	4.40040
	PROVIDER OR SUPPLIER A NURSING AND REI	HAB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	dated 7/23/19 and r following new interv Resident #44) on in consequences of expensions. Redirect needed. Medication Review of Resident plan dated 8/21/19 was not revised to r There was no evide with Resident #44. On 11/14/19 at 10:1 conducted with RN manager. When asl find a resident on to their brief undone, Fimmediately separat assessment on both signs of physical iss would make the phy the residents if able, also report this incid (Director of Nursing) stated that she would after the residents wincident could end u stated that she would progress notes as wassessment. RN #1 should also be revis staff on the incident RN #1 stated that fre be initiated for both of frequent monitoring stated to prevent the	revised 9/18/19, revealed the rentions: "Educate (Name of appropriate behaviors and whibiting inappropriate (Name of Resident #44) as as ordered." #14's comprehensive care revealed that her care plan	F	600			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	_		E SURVEY IPLETED
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, ST 1604 OLD DONATION PKY VIRGINIA BEACH, VA	WY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
F 600	needed as well. RN usually kept in a parecord. RN #1 state administrator report abuse to the appropasked who was the stated that it was the asked if could definith that sexual abuse wencounter that was that she was not inwith Resident #44 a stated that she was different unit (unit or currently did not have that both residents was asked if she counted that both residents was asked if she counted that both residents on 8/3 Con 11/14/19 at 11:1 minute checks for FResident #44 was possible to the counted with CN/Resident #44 and Resident #44 and Resident #44 and Resident #45 counds on Resident p.m., she went into Resident #44 laying	#1 stated that monitoring was per soft file, not in the clinical of that she believed the sed any incidents of alleged oriate state agencies. When abuse coordinator, RN #1 e facility administrator. When e sexual abuse, RN #1 stated as any type of forced sexual not consensual. RN #1 stated folved in the above incident and Resident #14. RN #1 the unit manager for a ne) and that the facility are a unit manager for the unit reside on (unit two). RN #1 uld provide any evidence that were conducted after these follows. 9 a.m., RN #1 presented q 15 lesident #44. Review of all check audits revealed that laced on every 15 minute no from 9/1/19 until 10/1/19. Ince that safety checks were st incident between Resident	F				

						NID INO	. UB30-U39 I	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019	
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	14/2013	
SENIAH	A NUHSING AND REF	IAB CENTER-WINDERMERE		1	/IRGINIA BEACH, VA 23454			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	place and her brief #1 her witness state #1 then stated that remembering but th Resident #14's brief have been undone. #44 was lying face of face in contact with her brief was undonexactly where Resident #14. CNA she called for the nuand the nurse assis her wheelchair. CNA Resident #44 back is she fixed Resident is she asked Resident did not get an answithat incident she corresidents and remeiat the nurses station time. CNA #1 stated p.m., she checked of Resident #44 again #1 stated that Resident #14's private she had also saw mouth. CNA #1 stated were open and that Resident #14's private she had also saw mouth. CNA #1 stated was also smilling Resident #14 was conappropriate touchithink so. When asked ensuring Resident #44, CNA #1 stated #44, C	ge 13 It #14 still had her gown in was intact. When shown CNA ament written on 8/30/19, CNA she was having a hard time at if she had written that it was undone, than it must CNA #1 stated that Resident down on Resident #14; her Resident #14's skin because e. CNA #1 could not recall lent #44's head aligned with #1 then stated at this moment urse (LPN #3), and both her ted Resident #44 back into A #1 stated that they brought into her room. CNA #1 stated that #44 what she was doing but er. CNA #1 stated that after intinued to do rounds on her inbered seeing Resident #44 had saw in Resident #14's gown and brief Resident #44 had her hand in the area. CNA #1 stated that oney in Resident #14's ed that Resident #14's ed that Resident #44 was a doing and that Resident #44 ka #1 stated that Resident #44	F	600				

A	TATEMENT ND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
			495392	B. WING			11/	14/2019
	SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	ODE		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
	;	#44 did not re-enter #1 stated that she to after the first encour rounds on her resid did not recall signing check" sheet after could not recall much because she gave rafter. CNA #1 stated statement of the two conducted with LPN both incidents on 8/2 conducted with LPN both incidents on 8/2 could recall that shift CNA came and grat LPN #3 stated that she #44 had fallen on to stated that she thou up from her wheelch Resident #14. When presented when she her, LPN #3 stated? Resident #14 looked disheveled or in dist could not remember undone but if, she wundone in her witner was probably undon #14 had the capacit #3 stated that Resident #15 stated that Resident #16 stated that Resident #17 stated that Resident #18	Resident #44's room. CNA ried to watch Resident #44 nter but that she had to ents. CNA #1 stated that she gany "q (every) 15 minute the first incident. CNA #1 ch after the second incident report and went home shortly dithat she did write a princidents that same day. Op.m., an interview was 1 #3, the nurse who witnessed 30/19. When asked what she fit, LPN #3 stated that the obed her and looked frantic. She was told that Resident p of Resident #14. LPN #3 ght Resident #44 had gotten hair, lost balance and fallen on he asked how Resident #14 esaw Resident #44 on top of that she couldn't recall what dike, but that she didn't look ress. LPN #3 stated that she rif Resident #14's brief was ses statement, then her brief was ses statement, then her brief was ses statement, then her brief was the combative, she had a edisheveled. LPN #3 stated to toe assessment on both Jury because she had thought allen on Resident #14. When 4 was able to consent to any #3 stated, "Our brains didn't lated that after the first."	F 6	500			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		495392	8. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		14/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	back to her room. Lafter the CNA grabb went into the Reside Resident #44 active #14's mouth and Reundone. LPN #3 starounding on Reside incident. LPN #3 stafirst incident was se thought the second situation." LPN #3 state thought the second situation." LPN #3 an assessment after residents and there #3 stated that Residents and there #3 stated that Residents and there asked if she documented what sithat she did not initial minute check audit. reported the two incidents and the was not the assor Resident #44 and nurse know. LPN # witness statement that she did not reported that DON or asked who the abus stated that DON or abuse coordinator. Variable allegation of any that allegations of all immediately, "even it LPN #3 confirmed the state of any that allegations of all immediately, "even it LPN #3 confirmed the state of the stat	PN #3 then stated shortly bed her again and when she ent #14's room, she saw by putting money in Resident esident #14's brief was sted that they did not start int #44 until after the second ated that they did not think the xual in nature but then incident was a "weird tated that looking back now, ald have been a sexual stated that she had conducted in the second incident on both were no obvious injuries. LPN then the second encounter. When ented safety checks stated that she just the had done during her shift, ate a paper q (every) 15 When asked if she had idents, LPN #3 stated that she wrote a nat shift. LPN #3 confirmed on these incidents to the N (Director of Nursing). When he coordinator was, LPN #3 clinical manager was the Nhen asked when to report type of abuse, LPN #3 stated on the middle of the night." nat her witness statement was the DON when she returned	F6	00			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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NAME OF I	PROVIDER OR SUPPLIER	100002	0			11/	<u>14/2019 </u>
SENTAR	A NURSING AND REF	AB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From particles of the state of that the was not surface of Operations about the VP of Operation reports after hours after hours. When a state of that the state of the sta	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI	BE GIATE	
	allegations of abuse immediately to her (#1 stated that abuse two hours to the appabuse had caused to	e should be reported the abuse coordinator). ASM e should be reported within propriate state agencies if bodily harm or within 24 hours. esident #44 was placed on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495392	B. WING				
	PROVIDER OR SUPPLIER	IAB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454	<u> 11/</u>	<u>14/2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	prevent any further with other residents On 11/14/19 at 9:59 interviews were atteassigned nurse that	ng 9/1/19, ASM #1 stated to episodes of sexual behavior	F6	00			
;	Nursing) were made						
	following: " Sexual sexual contact of ar Identification: It is the residents/participant identify potential signoccurrences, patter constitute abuse will Abuse policy require resident/participant alleged offender Timmediately remove protected. If the alle resident/participant, immediately remove situation and another the alleged perpetral instruction from the Examine, assess, a resident/participant residents/participant immediately to determine the sexual sexua	the staff members will the perpetrator from the er staff member will stay with tor and wait for further administrator, if possible. and interview the					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY PLETED
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SENTAR		IAB CENTER-WINDERMERE		1604	EET ADDRESS, CITY, STATE, ZIP CODE I OLD DONATION PKWY GINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From particle (1) Lewy body deme	ge 18 entia *(LBD) is a disease ormal deposits of a protein	F6	00			
	called alpha-synucle deposits, called Lew the brain whose cha problems with thinki	ein in the brain. These by bodies, affect chemicals in linges, in turn, can lead to ling, movement, behavior, and					
	mood. Lewy body de common causes of was obtained from T Health.	ementia is one of the most dementia." This information The National Institutes of					
į	mentia#what. (2) Perphenazine is	gov/health/what-lewy-body-de an antipsychotic used to treat information was obtained					
	https://www.ncbi.nln (3) Mirtazapine is ar major depressive dis obtained from The N	n.nih.gov/books/NBK548366/. n antidepressant used to treat sorder. This information was lational Institutes of Health.					
	(4) Risperdol (Rispe antipsychotic that is of mania and schizo	n.nih.gov/books/NBK548216/. ridone) is an atypical used widely in the treatment phrenia. This information was lational Institutes of Health.					
	https://www.ncbi.nim (5) Zoloft (Sertraline reuptake inhibitor (S depression, anxiety obsessive-compulsion	n.nih.gov/books/NBK548906/) is a selective serotonin SRI) used in the therapy of disorders and we disorder. This information					
F 607	was obtained from T Health. https://www.ncbi.nlm Develop/Implement.	he National Institutes of n.nih.gov/books/NBK548513/. Abuse/Neglect Policies	F 60)7 1.	. Resident #14 was monitored for any		
SS=D	CFR(s): 483.12(b)(1 §483.12(b) The facil implement written po				adverse effects from the encounter. adverse outcomes were observed.		
				- 1		F	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	SUMMARY STA	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	VI IX	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 607	neglect, and exploit misappropriation of §483.12(b)(2) Estat to investigate any signs of several sever	bit and prevent abuse, ation of residents and resident property, blish policies and procedures uch allegations, and de training as required at IT is not met as evidenced record review, facility document record review, it was sility staff failed to implement of 38 residents in the survey esident #14 was free from a punter by Resident #44 that by and failed to report and to the facility administrator at state agencies in a timely ed: dmitted to the facility on oses that included but were	F	607	 All residents are at risk when abuse policies are not implemented and potential abuse situations are not reported in a timely manner. Staff in all departments will be educated on the facility abuse policy to include to identify abuse, appropriate action take to ensure resident safety, and the process for escalating unusual occurrences or potential abuse situated to Administrative staff. A 100% audit of current employee fill ensure staff has completed training of facility abuse policy. Random audits staff to include identifying abuse, intervention for resident safety, and escalation process will be conducted week for two weeks, weekly x two we then monthly x 2 months. Audits will shared with QAPI committee with revisions to action plan as needed be on audit results. Date of Completion December 27, 26 	ated to to he tions les to on s of at 3X a eeks, ll be ased	

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING AND REHAB CENTER-WINDERMERE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 495392 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SUI COMPLET	
SENTARA NURSING AND REHAB CENTER-WINDERMERE STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE	, , , , , , , , , , , , , , , , , , , ,		B. WING		11/14/2	019
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE COMP	SENTARA NURSING AND RE	HAB CENTER-WINDERMERE		1604 OLD DONATION PKWY	1 11 1 - 11 2	
	PRÉFIX (EACH DÉFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BF COL	(X5) MPLETION DATE
one staff member with bed mobility, and dressing; and total dependence on staff with personal hygiene. Resident #44 was admitted to the facility on 3/23/17 with diagnoses that included but were not limited to Schizophrenia, major depressive disorder, anxiety disorder and dementia with Lewy Bodies (1). Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an AR10 (assessment reference date) of 9/30/19. Resident #44 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (first Interview for Mental Status) exam. Resident #44 was coded as requiring limited assistance with one staff member with transfers, locomotion, dressing, and personal hygiene; and independent with bed mobility and meals. Review of Resident #44's clinical record revealed a nursing note dated 8/30/19 that documented the following: "At 2110 (9:10 p.m.) this evening this nurse was grabbed by another staff worker and brought to a different resident's room to find this resident (Resident #44) face down on top of another resident (Resident #14). Neither resident appeared to have any injuries. This resident is at baseline and was questioned about what happened but will not answer. Will continue to monitor." A second nursing note dated 8/30/19 revealed a second incident with Resident #14 that documented the following: "Resident #14) while she was sitting in wheelchair at bedside 10:30 p.m. When nurse checked the other resident's	one staff member of and total depender hygiene. Resident #44 was a 3/23/17 with diagnor limited to Schizoph disorder, anxiety di Lewy Bodies (1). R MDS (minimum da quarterly assessme reference date) of scoded as being into 15 out of 15 on the Mental Status) examenber with transit personal hygiene; a mobility and meals. Review of Resident a nursing note date the following: "At 2" this nurse was gratiand brought to a difficult this resident (Resident another resident	with bed mobility, and dressing; noe on staff with personal admitted to the facility on oses that included but were not renia, major depressive sorder and dementia with desident #44's most recent ta set) assessment was a sent with an ARD (assessment 9/30/19. Resident #44 was eact in cognitive function scoring BIMS (Brief Interview for m. Resident #44 was coded as sistance with one staff fers, locomotion, dressing, and and independent with bed and independent with bed to 110 (9:10 p.m.) this evening obed by another staff worker ferent resident's room to find lent #44) face down on top of tesident #14). Neither resident any injuries. This resident is at juestioned about what not answer. Will continue to ote dated 8/30/19 revealed a h Resident #14 that lowing: "Resident (Resident staff pushing paper into mouth (Resident #14) while theelchair at bedside 10:30	F 6	07		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER SENTARA NURSING AND REHA	AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, 2 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454			142013
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
belonged to resident put the money in the answer but was laug station for close obsections." There was no evident any previous history 8/30/19. Review of the FRI (farevealed that the fact the appropriate state following was docum." "Incident date 9/1/19 reported that resident discovered in resident wo occasions and the making sexual advartions failed to send and the second time on "9-4-Review of witness statement of who witness et incide 9:30 p.m., I saw (Narroom of (Name of Refront of (Name of Refront of Name	lar bill in her mouth that . When questioned why she resident's mouth-would not hing. Was placed as nurse's ervation as was still awake. Ity in wheelchair at nurses' ace that Resident #44 had of sexual behaviors prior to acility reported incident) ility did not submit a FRI to agencies until 9/4/19. The tented: ; Report date: 9/3/19: Staff at (Resident #44) was not (Resident #14) room on hat she appeared to be not top of the FRI wing: "9-3-19 4:06 p.m." on top of the FRI wing: "9-3-19 4:06 p.m." arevealed that the fax had a FRI was submitted a 19 at 8:30 a.m."	F	607			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	_	ONSTRUCTION		E SURVEY MPLETED
		495392	B. WING			111	14/2019
		AB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY GINIA BEACH, VA 23454	, , , , ,	142010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 607	(Resident #14's) be Resident #14's) brid #14's) mouth." Witness statement Practical Nurse) #3: (approximately) 212 to me and said she ran down the hall to and find (Resident ilegs and her brief unher chair and helpe approximately 2230 as found again in (Fibrief undone but this dollar bill down her asked what she was (Resident #44) was monitoring. We aga doing and she state the (sic) started to gnurses station."	me of Resident #44) sitting in d trying to open (Name of ef and money on (Resident collected by LPN (Licensed: "8/3019: At approx." 20 (9:20 p.m.) a CNA came up needed my help STAT. So we enter (room of Resident #14) #44) lying on top of residents indone. We assisted her into d her into her room. At (10:30 p.m.). (Resident #44) Resident #14's room); again is time she was shoving a \$10 throat. I pulled it out and is doing and she just giggled. brought to nurses station for in asked her what she was d, "She called me in there." jiggling again. Will keep at	Fe	07			
	from the nurse (LPN #44 on 8/30/19 to the Operations (not the Objector of Nursing at 4:08 a.m. The followanted to make you actually 2 that happ p.m staff found (Name apparent injuries and was taken back to hat staff again found (R wheelchair besides	W #1) assigned to Resident of administrator) and the DON (administrator) and the DON (b). The was written on 8/31/19 lowing was documented: "I (a aware of an incident bened on my shift 8/30, at 9 ame of Resident #44) lying in the of Resident #14). No (Name of Resident #44) are room. Then at 10:30 pmesident #44) sitting in her (Resident #14) bed stuffing a routh while laughing.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		495392	B. WING			111	145010
	PROVIDER OR SUPPLIER A NURSING AND REA	AAB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		14/2019
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	we took (Resident and her with staff all nigher with staff all nigher or in small dining reduction besides chart incided did write a STARS (reporting system) reduced has (Name of Healt contact- she is more maybe dangerous to if there is anything on a evidence that the made aware of the 9/2/19 (when an involved the system). The five-day follow faxed to the approper The following was dwriter (facility adminifulation with the system). The system of the system of the sexual advantable of Resident #14), Resident #14), Resident #14), Resident #44) was towards (Name of Finot substantiated durintent to (Resident #4) cossident #44) does behaviors but has naggressiveness or in admission. This new	ge 23 #14) not harmed and again #14) out of the room and kept ht - either at the nurses station rom. I was unsure what to do ents, put in doctor's book and I mame of internal incident eports. (Name of Resident #44 hcare organization) as #1 e confused now & (and) to the residents? Let me know else to be done" There was e facility administrator was above two incidents until estigation was initiated). up FRI was completed and riate state agencies on 9/6/19. locumented in part; "This histrator) interviewed (Resident att. (Name of Resident #44) ifficulty with her recall but ered being in the room and ad (Name of Resident #14) he was trying to help her. her she was attempting to ces towards (Name of dent #44 stated that she was beservations of staff and the vents it appears that (Name his making sexual advances hesident #14). Sexual abuse is he to the inability to assign he felusions. (Name of not have a history of ot demonstrated sexual happropriateness since her hy behavior does present a risk follow up action will be	F	607			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	1		E SURVEY PLETED
		495392	B. WING _			11/1	14/2019
		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD E	BE :	(X5) COMPLETION DATE
F 607	conducted with RN unit manager. Whe were to find a reside with his or her brief she would immedia an assessment on I signs of physical iss would make the phy the residents if able also report this incide. (Director of Nursing stated that she wou after the residents wincident could end ustated that frequent initiated for both residents frequent monitoring stated to prevent the RN #1 stated that is reported any incider appropriate state agwas the abuse coor was the facility admicould define sexual sexual abuse was a encounter that was. There was no evide initiated after the firm #44 and Resident #minute checks were On 11/14/19 at 1:39 conducted with CN/#1, the CNA who wi	(Registered Nurse) #1, the n asked the process if she ent on top of another resident undone, RN #1 stated that tely separate the residents, do both residents "looking for any sues". RN #1 stated that she ysician aware and interview of RN #1 stated that she would dent immediately to the DON of and Administrator. RN #1 and start an investigation soon were separated because the up being sexual abuse. RN #1 monitoring would also be sidents. When asked why would be initiated, RN #1 e resident from doing it again, he believed the administrator ints of alleged abuse to the gencies. When asked who dinator, RN #1 stated that it inistrator. When asked if abuse, RN #1 stated that any type of forced sexual	F 60	07			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		495392	8. WING	1		11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REI	HAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, 2 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		• • • • • • • • • • • • • • • • • • • •	142010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 607	#14 was safe from that it was a team or responsible for ensignment of the tension of the two was left for the Direct on 11/14/19 at 12:3 conducted with LPN both incidents on 8 Resident #14 was a activity, LPN #3 state ther and the CNA brown her room. LPN #3 to CNA grabbed her at the Resident #14's actively putting morand Resident #14's stated that they did #44 until after the sthat they did not the two as a "weird situation looking back now, to been a sexual encoord Resident #44 was keep the second encount documented safety stated that she just done during her shipaper q (every) 15 masked if she had re #3 stated that she versident #14 or Resident	Resident #44, CNA #1 stated affort, that everyone was uring Resident #44 did not 44's room. CNA #1 stated that Resident #44 after the first she had to round on her stated that she did write a o incidents that same day that	F	607			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		495392	B. WING		441	142010
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	1 11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	36 C	(X5) COMPLETION DATE
F 607	#3 confirmed that s incidents to the adm Nursing). When ask coordinator, LPN #3 manager was the all asked when to report abuse, LPN #3 state should be reported middle of the night. witness statement v DON when she return Monday. On 11/14/19 at apprinterview was condustaff member) #1, the when she was made between Resident # #1 stated that she between Resident # #1 stated that she between the interim VP (Vice notified her. ASM #1 (LPN #1) had filled creporting system) or of Operations about the VP of Operation after hours on the was not sure if staff hours. When asked report these two incidents	ness statement that shift. LPN he did not report these ninistrator or DON (Director of sed who was the abuse 3 stated that DON or clinical buse coordinator. When are an allegation of any type of ed that allegations of abuse immediately, "even in the LPN #3 confirmed that her was left at the facility for the area to work the following roximately 3:00 p.m., an acted with ASM (administrative ne Administrator. When asked a aware of the two incidents and Resident #44, ASM recame aware on 9/2/19 when a President) of Operations had a stated that the nurse on shift out a STARS report (incident in 8/30/19 that alerted the VP the incidents. When asked if s checks the STARS reports reekend, ASM #1 stated that SM #1 also stated that she were checking email after if she expected her staff to idents sooner, ASM #1 stated	F 6			
	feel that the first inc that the situation wa the staff went throug reporting process. A #44 also had no pre behaviors. When as	r situation, the staff did not ident was abuse, they just felt is "weird". ASM #1 stated that is the normal incident ISM #1 stated that Plesident vious history of sexual level about reporting the M #1 stated that the second				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING			E SURVEY IPLETED
		495392	B. WING	3		44.6	14/0010
	PROVIDER OR SUPPLIER A NURSING AND REH	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP C 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	XODE	11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD	BĘ	(X5) COMPLETION DATE
F 607	me" but then stated the incident manage that maybe reportin management system. When asked when allegation of abuse, allegations of abuse, allegations of abuse, allegations of abuse immediately to her (#1 stated that abuse two hours to the appabuse had caused I When asked why R safety checks starting prevent any further with other residents. On 11/14/19 at 9:59 interviews were atteassigned nurse that not be reached for a left asking for a return to be reached for a left asking for a return to exit. The facility's abuse following: " Sexual concerns. No furthe prior to exit. The facility's abuse following: " Sexual sexual contact of an Identification: It is the residents/participant identify potential sig Occurrences, patter constitute abuse will Abuse policy required.	hould have been reported to it was reported to her through ement system. ASM #1 stated g through the incident m was "not the most efficient." staff should report any ASM #1 stated that a should be reported (the abuse coordinator). ASM a should be reported within propriate state agencies if codily harm or within 24 hours. esident #44 was placed on ang 9/1/19, ASM #1 stated to episodes of sexual behavior a.m., and 3:07 p.m., empted with LPN #1, the shift on 8/30/19. She could an interview. A message was im call.	F	607			

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY
		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	117	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 607	immediately remove protected. If the alie resident/participant, immediately remove situation and anothe the alleged perpetra instruction from the Examine, assess, a resident/participant residents/participant immediately to dete immediately to dete immediate clinical ir facility will ensure the involving abuse, negmistreatmentare in the facility and to other state survey agency where state law procare facilities) in account immediately, it the allegation involve attinjury, or not later the cause the allegation not result in serious (1) Lewy body demeassociated with abnicalled alpha-synucled deposits, called Lew the brain whose chaproblems with thinkit mood. Lewy body decommon causes of was obtained from Thealth.	The alleged perpetrator will be ad and the resident/participant aged perpetrator is a the staff members will at the perpetrator from the ar staff member will stay with attor and wait for further administrator, if possible, and interview the and other and other and other and injury and identify atterventions necessaryThe lat all alleged violations of glect, exploitation or eported to the administrator of the officials (including to the and adult protective services vides jurisdiction in long term cordance with State law procedures. Reporting must but not later than 2 hours after de if the events that cause the buse or result in serious bodily an 24 hours if the events that a did not involve abuse or do	Fé	07			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019	
SENTARA NURSING AND REHAB CENTER-WINDERMERE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI) TAG	16 VII	REET ADDRESS, CITY, STATE, ZIP CODE 04 OLD DONATION PKWY RGINIA BEACH, VA 23454 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI	N BE	(X5) COMPLETION DATE	
F 609 SS=D	neglect, exploitation must: §483.12(c)(1) Ensurinvolving abuse, nemistreatment, include source and misapper are reported immed hours after the allegs that cause the allegs serious bodily injury the events that cause abuse and do not rest the administrator of officials (including to adult protective service for jurisdiction in lon accordance with Staprocedures. §483.12(c)(4) Repositives the designated represent accordance with Stapropriate correction. §483.12(c)(4) Repositives and if the appropriate correction in longer accordance with Stapropriate correction. §483.12(c)(4) Repositives accordance with Stapropriate correction in longer accordance with Stapropriate correction. §483.12(c)(4) Repositives accordance with Stapropriate correction in longer accordance with Stapropriate correction. §483.12(c)(4) Repositives accordance with Stapropriate correction in longer accordance wit	d Violations (1)(4) Inse to allegations of abuse, or mistreatment, the facility The that all alleged violations glect, exploitation or ding injuries of unknown repriation of resident property, iately, but not later than 2 pation is made, if the events ation involve abuse or result in common or	F 6		1. No corrective action could be taken the reporting time frame had passe 2. All residents are at risk when poten abuse is not reported in a timely manner 3. Staff in all departments will be educated on abuse reporting timelin and procedures for escalating poten abuse scenarios and unusual occurrences. 4. A 100% audit of current employee to ensure staff has completed training on facility abuse reporting timelines Random audits of staff in all departments on escalation process suspected abuse or unusual occurrences will be conducted 3X as week for two weeks, weekly x two weeks, then monthly x 2 months. Audits will be shared with QAPI committee with revisions to action pas needed based on audit results. 5. Date of Completion December 27, 2019	n as d. ditial nes ntial files ing in		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		16	REET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY RIGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	#14) to the facility A appropriate State A appropriate State A The findings include Resident #44 was a 3/23/17 with diagno limited to Schizophr disorder, anxiety dis Lewy Bodies (1). Re MDS (minimum dat quarterly assessme reference date) of 9 coded as being inta 15 out of 15 on the Mental Status) exar requiring limited ass member with transfepersonal hygiene; a mobility and meals. Resident #14 was a 11/14/13 with diagnot limited to demend disturbance and mu #14's most recent May quarterly assessme reference date) of 8	Resident #44 and Resident dministrator and to the gencies in a timely manner. ed: dmitted to the facility on ses that included but were not enia, major depressive corder and dementia with esident #44's most recent a set) assessment was a nt with an ARD (assessment /30/19. Resident #44 was cot in cognitive function scoring BIMS (Brief Interview for n. Resident #44 was coded as sistance with one staffers, locomotion, dressing, and not independent with bed dmitted to the facility on oses that included but were	Fe	09	OEFICIENCY)		
	function scoring 01 d BIMS (Brief Intervier Resident #14 was c sometimes being un sometimes understa was coded as required one staff member w	out of possible 15 on the w for Mental Status) exam. oded in Section B as oderstood by staff and anding staff. Resident #14 ring extensive assistance with ith bed mobility, and dressing; see on staff with personal				·	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY
		Carrie Carron Homber.	A. BUILE	DING		CON	MPLETED
NAME OF	PROVIDER OR SUPPLIER	495392	B. WING			11/	14/2019
	A NURSING AND REI	IAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 31	F	809			
	a nursing note dated the following: "At 21 this nurse was grab and brought to a diff this resident (Reside another resident (Reside another resident (Reside appeared to have as baseline and was que happened but will not monitor." A second nursing not second incident with documented the folle #44) observed by 2 another resident's make was sitting in what p.m. When nurse chemouth-was a ten-do belonged to resident put the money in the answer but was laught station for close observed that the fact the appropriate state following was document to a different to the state of the propriate state following was document."	owing: "Resident (Resident staff pushing paper into nouth (Resident #14) while neelchair at bedside 10:30 necked the other resident's llar bill in her mouth that it. When questioned why she resident's mouth-would not phing. Was placed as nurse's nervation as was still awake. It will be in the properties of the proper					
	reported that resider discovered in resider	r; Report date: 9/3/19: Staff at (Resident #44) was nt (Resident #14) room on nat she appeared to be noes towards her."					

ATATEMENT							1000 0001
AND PLAN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		E SURVEY IPLETED
		495392	B. WING	i		11/	14/2019
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	14/2019
SENTAR	A NURSING AND REL	IAB CENTER-WINDERMERE			804 OLD DONATION PKWY		
		IND CERTER-WINDERMERE		V	IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 32	F	509			
-	This fax confirmation failed to send and the second time on "9-4" Review of witness s	lowing: "9-3-19 4:06 p.m." on revealed that the fax had ne FRI was submitted a I-19 at 8:30 a.m."					
	who witnessed incices: 30 p.m., I saw (Na room of (Name of Room to (Name of Room to her knee. Call me get her up. At 16 went to the room to #14) and I saw (Name (Resident #14's) because it is the same of the room to the room to the room to #14) and I saw (Name (Resident #14's) because it is the room to the room to the room to #14) and I saw (Name (Resident #14's) because it is the room to the room t	collected by CNA (CNA #1) lents: "8/30/19 Friday @ (at) ame of Resident #44) at the lesident #14) face down in esident #14) with open brief ed (Name of nurse) to help 0:15 p.m. after my rounds I check (Name of Resident me of Resident #44) sitting in d trying to open (Name of left and money on (Resident					
	Practical Nurse (LPI (approximately) 212 to me and said she ran down the hall to and find (Resident # legs and her brief ur her chair and helped approximately 2230 as found again in (R brief undone but this dollar bill down her t asked what she was (Resident #44) was monitoring. We agai doing and she stated	collected by Licensed N) #3: "8/3019: At approx. 0 (9:20 p.m.) a CNA came up needed my help STAT. So we enter (room of Resident #14) 44) lying on top of residents adone. We assisted her into d her into her room. At (10:30 p.m.). (Resident #44) resident #14's room); again stime she was shoving a \$10 hroat. I pulled it out and doing and she just giggled, brought to nurses station for a sked her what she was d, "She called me in there."					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER A NURSING AND REF	HAB CENTER-WINDERMERE		1.	STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		Passis
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From panurses station." An email was attact from the nurse (LPI #44 on 8/30/19 to the DON (Director of Nion 8/31/19 at 4:08 adocumented: "I wan incident -actually 8/30, at 9 p.m staf #44) lying in bed on #14). No apparent in Resident #44) was at 10:30 pm- staff a sitting in her wheeld bed stuffing a 10 do laughing. (Name of and again we took (and kept her with st nurses station or in unsure what to do be doctors book and I dinternal incident repof Resident #44 has organization) as #1 confused now & (and residents? Let me k to be done" There facility administrator above two incidents investigation was in The five-day follow the confused to the confused to the confused now as in the five-day follow the confused to the confused now as in the five-day follow the confused follows th	hed the witness statements N #1) assigned to Resident he Facility Vice President of a facility administrator) and the lursing). The email was written a.m. The following was ranted to make you aware of y 2 that happened on my shift if found (Name of Resident in top of (Name of Resident injuries and (Name of taken back to her room. Then again found (Resident #44) chair besides (Resident #14) ollar bill into her mouth while Resident #14) not harmed (Resident #14) out of the room taff all night - either at the small dining room. I was besides chart incidents, put in did write a STARS (name of corting system) reports. (Name of Name of Healthcare contact- she is more and) maybe dangerous to the know if there is anything else a was no evidence that the r was made aware of the suntil 9/2/19 (when an		609	DEFICIENCY)	RIATE	DATE
	The following was d writer (facility admin #44) regarding even	indice state agencies on 9/6/19. diocumented in part; "This nistrator) interviewed (Resident nt. (Name of Resident #44) lifficulty with her recall but				9	

STATEMENT AND PLAN (TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	TIPLE CONSTR		(X3) DAT	E SURVEY
		495392	B. WING				la almana
		IAB CENTER-WINDERMERE		1804 OLD E	DRESS, CITY, STATE, ZIP CODE DONATION PKWY BEACH, VA 23454	11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	K (E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD ISS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
	stated she remember that she had followed there. She stated she when asked whether make sexual advanted Resident #14), Resident #14), Resident #14), Resident #14) was towards (Name of Resident #14) was towards (Name of Resident #14) does behaviors but has not aggressiveness or in admission. This new and the appropriate taken." On 11/14/19 at 10:13 conducted with RN (unit manager. When were to find a reside with his or her brief to she would immediate an assessment on be signs of physical issue would make the p	ge 34 ered being in the room and ed (Name of Resident #14) he was trying to help her. her she was attempting to ces towards (Name of dent #44 stated that she was beervations of staff and the vents it appears that (Name is making sexual advances resident #14). Sexual abuse is reto the inability to assign reto the inability of actions due to her reto the delusions. (Name of not have a history of the demonstrated sexual appropriateness since her resident appropriateness since her resident appropriateness if she not on top of another resident and one, RN #1 stated that reto the residents "looking for any uses". RN #1 stated that she would ant immediately to the DON and Administrator. RN #1 stated that it mistrator. When asked who linator, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator. When asked if abuse, RN #1 stated that it instrator.	F	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495392	B. WING		111	/14/2019
		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		714/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 609	encounter that was On 11/14/19 at 12:3 conducted with LPN both incidents on 8/ Resident #14 was a activity, LPN #3 state her and the CNA bn her room. LPN #3 tl CNA grabbed her a the Resident #14's actively putting mon and Resident #14's stated that they did #44 until after the se that they did not thir in nature but then th was a "weird situatio looking back now, th been a sexual enco- reported the two inc she was not the ass or Resident #44 and nurse know. LPN # witness statement th that she did not repo administrator or DO asked who was the stated that DON or o abuse coordinator. N an allegation of any that allegations of al immediately, "even i LPN #3 confirmed th left at the facility for to work the following	not consensual. 10 p.m., an interview was 1 #3, the nurse who witnessed 130/19. When asked if able to consent to any sexual ted, "Our brains didn't go ed that after the first incident, ought Resident #44 back to hen stated shortly after the gain and when she went into room, she saw Resident #44 bey in Resident #14's mouth brief was undone. LPN #3 not start rounding on Resident econd incident. LPN #3 stated ask the first incident was sexual bought the second incident ton." LPN #3 stated that the first incident could have unter. When asked if she had idents, LPN #3 stated that igned nurse for Resident #14 If that she had let the assigned 3 also stated that she wrote a nat shift. LPN #3 confirmed but these incidents to the N (Director of Nursing). When abuse coordinator, LPN #3 clinical manager was the When asked when to report type of abuse, LPN #3 stated buse should be reported in the middle of the night."	F 60)9		

AND PLAN	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	0.00	495392	B. WING			14/2019		
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP COI 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		117	14/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	E ATE	(X5) COMPLETION DATE	
	interview was condi- staff member) #1, the when she was made between Resident # #1 stated that she is the interim VP (Vice notified her. ASM # (LPN #1) had filled or reporting system) or of Operations about the VP of Operation after hours on the was not sure. A was not sure if staff hours. When asked report these two incithat in this particular feel that the first incithat the situation was the staff went through reporting process. A #44 also had no prebehaviors. When as second incident, AS incident "probably sime" but then stated the incident manage that maybe reporting management system. When asked when sallegations of abuse allegations of abuse immediately to her (if #1 stated that abuse two hours to the appabuse had caused both incident manage.	acted with ASM (administrative ne Administrator. When asked a aware of the two incidents 14 and Resident #44, ASM necame aware on 9/2/19 when President) of Operations had I stated that the nurse on shift out a STARS report (incident necessary) and the incidents. When asked if it is is checking the Stars report necessary report necessary report necessary	F 6	09				

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
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MANEOE	PROVIDER OR SUPPLIER	495392	B. WING			11/	14/2019
SENTAR	A NURSING AND REI	HAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF	(X5) COMPLETION DATE
	on 11/14/19 at 4:27 administrator and A Nursing) were made concerns. No furthe prior to exit. The facility's abuse following: " The facility's abuse following: " The facility abuse following to the state protective services of including to the state protective services of the concept of th	t shift on 8/30/19. She could an interview. A message was urn call. I p.m., ASM #1, the SM #2, the DON (Director of a aware of the above or information was presented policy documents in part, the cility will ensure that all alleged ag abuse, neglect, exploitation be reported to the facility and to other officials the survey agency and adult where state law provides form care facilities) in the law through establisheding must occur immediately, mours after the allegation is that cause the allegation of the events that cause the tinvolve abuse or do not	F	609	DEFICIENCY)		
	was obtained from T Health.	he National Institutes of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/26/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING ... COMPLETED 495392 B. WING 11/14/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY SENTARA NURSING AND REHAB CENTER-WINDERMERE VIRGINIA BEACH, VA 23454 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 622 Transfer and Discharge Requirements F 622 1. Resident #4, #45, #12, #67 and #55 SS=E CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) were readmitted to the facility without incident. Resident #70 was accepted §483.15(c) Transfer and dischargefor readmission to the facility but did §483.15(c)(1) Facility requirements-(i) The facility must permit each resident to not return. remain in the facility, and not transfer or All resident who are discharged from discharge the resident from the facility unlessthe facility are at risk when the (A) The transfer or discharge is necessary for the comprehensive care plan is not resident's welfare and the resident's needs provided to the receiving facility. cannot be met in the facility; Nursing staff will be educated on the (B) The transfer or discharge is appropriate process for sending the comprehensive because the resident's health has improved care plan to the receiving facility at the sufficiently so the resident no longer needs the services provided by the facility: time of discharge. (C) The safety of individuals in the facility is Clinical Managers or designee will endangered due to the clinical or behavioral conduct ongoing audits of 100% of status of the resident: discharged resident's charts to ensure (D) The health of individuals in the facility would care plan summaries are sent at the otherwise be endangered; time of discharge. Results of audits will (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid be shared with the QAPI committee. under Medicare or Medicaid) a stay at the facility. 5. Date of Completion December 27. Nonpayment applies if the resident does not 2019 submit the necessary paperwork for third party

payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

(F) The facility ceases to operate.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REF	AB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		142018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8F	(X5) COMPLETION DATE
F 622	facility. The facility that failure to transf \$483.15(c)(2) Docu When the facility tra resident under any in paragraphs (c)(1) section, the facility ror discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility attenneeds, and the serviacility to meet the needs, and the serviacility to meet the needs, and the serviacility to meet the needs (a) or (b) of this section (c) The resident's period (d) The resident's period (d) The resident's period (e) A physician when necessary under pathis section. (iii) Information proving the include a minimal (c) Contact information (d) Resident representact information (e) Advance Directive (filter)	dent or other individuals in the must document the danger er or discharge would pose. mentation. Insfers or discharges a of the circumstances specified of the resident's must ensure that the transfer umented in the resident's appropriate information is e receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) Aragraph (c)(1)(i)(A) of this resident need(s) that cannot only the to meet the resident ice available at the receiving seed(s). In the required by paragraph (c) must be made by-hysician when transfer or ary under paragraph (c) (1) of tion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of tided to the receiving provider mum of the following: tion of the practitioner care of the resident. Entative information including	F	622			

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING			E SURVEY PLETED
	!	495392	8. WING			11/	14/2019
SENTAR	 	AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	CODE		1-12013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	86	(X5) COMPLETION DATE
F 622	ongoing care, as ap (E) Comprehensive (F) All other necess copy of the resident consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff interest and facility document failed to send a copplan to include the resident of the house of the survey sample (#45, & #12). The findings include 1. Resident #55 was facility on 10/30/17 and Alzheimer's disconditional and A	propriate. care plan goals; sary information, including a statischarge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure transition of care. IT is not met as evidenced rviews, clinical record review intation review, the facility staff by of the comprehensive care residents goals after being respital for 6 of 38 residents in residents #55, #70, #67, #4, ad: residents #55, #70, #67, #4, residents Hypercalcemia rease. rum Data Set (MDS) an ment with an assessment residental Status (BIMS), skills for decision making reing severely impaired for rig. ling to the facility's ident #55 departed the facility	F6	522			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING				4.460.40
		AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP O 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	CODE	11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
	are sent when a reshospital. LPN #6 stasheet, medication lipaper work and the would normally incluwith her documents. The above findings Administrator and Data approximately 4:3 were made. 2. Resident #70 was facility on 10/06/19 at approximately 4:3 were made. The quarterly Minimadmissions assessmelerence date (ARI resident with a 15 of on the Brief Interview indicating Cognitive intact. The Discharge MDS - discharge return not 10/18/19, accord documentation, Reswith transport to the On 11/14/19 at apprinterview was conduning Cognitive intact. On 10/18/19, accord documentation, Reswith transport to the On 11/14/19 at apprinterview was conduning (LPN) #6. She are sent when a residual. LPN#6 states	ident is being admitted to the ated, "I usually send the face st, the bed hold policy, DNR vital signs. When asked if she ated the care plan summary, she stated, "No." were shared with the birector of Nursing on 11/14/19 80 PM. No further comments as originally admitted to the and discharged on 10/18/19. The ses included: Repeated Falls sis. um Data Set (MDS) an an assessment by of 10/13/19, coded the fatotal possible score of 15 or Mental Status (BIMS), skills for decision making is assessment dated 10/18/19 of anticipated. ling to the facility's ident #70 departed facility	F	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENTIF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING 11/1			14/2019		
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	1.17	14/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	paper work and the When she was ask include the care plat documents, LPN #6 The above findings Administrator and Dat approximately 4:3 were made. 3. Resident #67's lawith a transfer to the 10/15/2019. The lanot limited to, acute gram-negative seps cardiomyopathy. Resident #67's mos Set) assessment with an date) of 8/14/2019. moderate cognitive possible 15 on the Emental status) example Areview of Resident revealed she was transfer to the 10/15/2019 due to be stools, observed due. Clinical record revise evidence that care put the hospital upon traconducted with the lawember #4) on 11/1 p.m. inquiring about care plan goals for Ferritage and comments.	vital signs. ed if she would normally in summary with her is stated "No." were shared with the Director of Nursing on 11/14/19 is PM. No further comments atest admission was 8/1/2019 is hospital occurring on itest diagnosis included, but posthemorrhagic, is, adult failure to thrive, and it recent MDS (Minimum Data as a 14 day Scheduled in ARD (assessment reference Resident #67 was coded as impairment scoring 14 out of BIMS (brief interview for in. it #67's clinical record ansferred to the hospital on bloody BM and black tarry ring change. ws conducted yielded no blan goals were submitted to	F	622				
	goals when she wer that we needed to de	it out. We were not aware						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495392	B. WING	i				
		AB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	11/	14/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFIC:ENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE	
F 622	findings during a brapproximately 4:15 present any further 4. Resident #4 was on 10/28/2015. Redischarge to the horeadmitted to the fadiagnosis included Stage Renal Diseas Dialysis and Type 2 Resident #4's Minimprotocol) with an As 11/04/2019 coded Finterview for Mental cognitive impairment Data Set coded Resextensive assistant dressing and person dependence of 1 with Con 11/13/2019 at apsurveyor requested comprehensive care the resident upon dialogologologologologologologologologolog	strator was informed of the iefing on 11/14/2019 at p.m. The Facility did not information about the findings. Initially admitted to the facility sident #4's most recent spital was on 10/02/2019 and cility on 10/26/2019. but were not limited to, End se, Dependence on Renal Diabetes Mellitus. num Data Set (an assessment sessment Reference Date of Resident #4 with a BIMS (Brief Status) of 13 indicating no nt. In addition the Minimum sident #4 as requiring e of 1 for bed mobility, nal hygiene and total th toilet use and bathing. Diproximately 9:00 a.m., the evidence that the eplan goals were sent with scharge to the hospital on opproximately 12:00 p.m., the l, "The resident was popital from the dialysis yor asked, "Were the care provided to the hospital?"	F	522				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
		495392	8. WING			11/	14/2019
SENTAR		AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	CODE		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 622	Unit 2 have more exunit 1 with sending hospital when residnurses should have the hospital." The Administrator a informed of the find 11/14/2019 at 4:25 present any further 5. Resident #45 was 7/3/17 and readmitt that included but we dementia without be cervical spinal cord. Resident #45's mos set) assessment was an ARD (assessment was an ARD (assessment was an ARD (assessment was an ARD (assessment #45 was c impaired in cognitive possible 15 on the EMental Status) exambeing totally depend all ADLs (activities of meals. Review of Resident that he was transfer The following nursin "Resident is LOA (le having ab (abdomin at the 6 pm the pain apart"	experience than the nurses on the care plan goals to the ents are discharged. The esent the care plan goals to and Director of Nursing was ing at the pre-exit meeting on p.m. The facility staff did not information about the finding, and admitted to the facility on ed on 11/9/19 with diagnoses are not limited to unspecified ehavioral disturbance, and	F	522			

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(2	X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/1//2010	ĺ
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	ODE	11/14/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	E COMPLETION DATE	*
F 622	conducted with RN unit manager. When sent with residents for an acute change that nursing staff she copy of medications notification. RN #1 swith the resident she nursing note. RN #1 nurses were suppost care plan goals. RN aware of that. On 11/14/19 at 4:27 Administrator and A Nursing were made No further informative exit. 6. Resident #12 was 8/14/19 and readmin diagnoses that include heart failure, dement #12's most recent N assessment was a care ARD (assessment resident #12 was compaired in cognitive possible 15 on the E Mental Status) examined that he had been see The following nursin part: "1400 (2:00 possible: "1400 (2:00 po	27 a.m., an interview was (Registered Nurse) #1, the n asked what documents were upon transfer to the hospital e in condition, RN #1 stated ould send the face sheet, a s, and the bed hold stated that documents sent ould be documented in a 1 stated that she wasn't sure if sed to send the care plan or 1 #1 stated that she wasn't p.m., ASM #1, the SM #2, the Director of aware of the above concerns. on could be presented prior to admitted to the facility on ted on 11/11/19 with ded but were not limited to, atia and diabetes. Resident	F	622			

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING AND REHAB CENTER-WINDERMERE DIAMAN STRICKLY NURSING AND REHAB CENTER-WINDERMERE EACH DEPOSITION OF CORRECTION SHOULD BE PROCUDED BY PULL REGULATORY OR LSC DENITIFINE INFORMATION) F 622 Continued From page 46 cath. Pending CBC (complete blood count) and BMP (Daste metabolic panel). Placed on 02 (oxygen) via NC (nasal cannuta) at 2 LPM (itera per mirule). 911 called. Transported to (name of hospital) at 1530 (3:30 p.m.) via ambulance There was no evidence in the clinical record that Resident #12's care plan or care plan goals were sent with the resident upon transfer to the hospital for an acute change in condition, RN #1 stated that unursing stift should send the face shear, a copy of medications, and the bed hold notification. RN #1 stated that documented in a nursing note. RN #1 stated that documented in a nursing note. RN #1 stated that she wasn't awer of that. On 11/14/19 at 4:27 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were mea ware of the above concerns. No further information could be presented prior to exit. Facility policy titled, "Transfer to Emergency Room of Hospital," did not address care plan goals or the comprehensive care plan. F 625 SS=E F 625 S483.15(d) Notice of bed-hold policy and return-	AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		PINSTRUCTION		DATE SURVEY COMPLETED	
SENTARA NURSING AND REHAB CENTER-WINDERMERE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICEMENT MILTS BE PRECEDED BY FULL REGULATION ON 150 DEMITPHING INFORMATION) F 622 Continued From page 46 cath. Pending CBC (complete blood count) and BMP (basic metabolic panel). Placed on 02 (oxygen) via NC (nasal cannuls) at 2 LPM (filers per minute). 911 called. Transported to (name of hospital) at 1530 (330 p.m.) via ambulance* There was no evidence in the clinical record that Resident #12's care plan or care plan goals were sent with residents upon transfer to the hospital for an acute change in condition, RN #1 stated that documents were sent with the resident supon transfer to the hospital for an acute change in condition, RN #1 stated that she wasn't aware of that. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the Director of Nursing were made aware of the above concerns. No further information could be presented prior to exit. Facility policy titled, "Transfer to Emergency Room of Hospital," did not address care plan goals or the comprehensive care plan of the plan or care plan goals or the comprehensive care plan goals goals or the comprehensive care plan goals			495392	B. WING			11/	14/2019	
PREFIX TAG REGULATORY OR LSC IDENTIFYME INFORMATION) F 622 Continued From page 46 cath. Pending CBC (complete blood count) and BMP (basic metabolic panel). Placed on 02 (oxygen) via NC (nasal cannula) at 2 LPM (filters per minute). 911 called. Transported to (name of hospital) at 1530 (3:30 p.m.) via ambutance* There was no evidence in the clinical record that Resident #12's care plan or care plan goals were sent with the resident output provided that nursing staff should send the face sheet, a copy of medications, and the bed hold notification. RN #1 stated that documents sent with the resident should be documented in a nursing note. RN #1 stated that documents sent with the resident should be documented in a nursing note. RN #1 stated that the wasn't sure if nurses were supposed to send the care plan or care plan goals. RN #1 stated that she wasn't aware of that. On 11/14/19 at 4:27 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the above concerns. No further information could be presented prior to exit. Facility policy titled, "Transfer to Emergency Room of Hospital," did not address care plan goals or the comprehensive care plan. Notice of Bed Hold Policy Before/Upon Trmsfr CFR(s): 483.15(d)(1)(2)	SENTAR	A NURSING AND REI			1604	OLD DONATION PKWY			
cath. Pending CBC (complete blood count) and BMP (basic metabolic panel). Placed on 02 (oxygen) via NC (nasal cannula) at 2LPM (liters per minute). 911 called. Transported to (name of hospital) at 1530 (3:30 p.m.) via ambulance* There was no evidence in the clinical record that Resident #12's care plan or care plan goals were sent with the resident upon transfer to the hospital. On 11/14/19 at 10:27 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked what documents were sent with residents upon transfer to the hospital for an acute change in condition, RN #1 stated that nursing staff should send the face sheet, a copy of medications, and the bed hold notification. RN #1 stated that documents sent with the resident should be documented in a nursing note. RN #1 stated that she wasn't sure if nurses were supposed to send the care plan or care plan goals. RN #1 stated that she wasn't sure if nurses were supposed to send the care plan or care plan goals. RN #1 stated that she wasn't aware of that. On 11/14/19 at 4:27 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the above concerns. No further information could be presented prior to exit. Facility policy titled, "Transfer to Emergency Room of Hospital," did not address care plan goals or the comprehensive care plan. Goals or the comprehensive care plan to the facility prior to the authority the defeat-the comprehensive care plan.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION	
Room of Hospital," did not address care plan goals or the comprehensive care plan. F 625 Notice of Bed Hold Policy Before/Upon Trnsfr SS=E CFR(s): 483.15(d)(1)(2) F 625 1. Residents #4, #45, #12, and #55 were all readmitted to the facility prior to the	F 622	cath. Pending CBC BMP (basic metabo (oxygen) via NC (na per minute). 911 cathospital) at 1530 (3 There was no evide Resident #12's care sent with the resident hospital. On 11/14/19 at 10:2 conducted with RN unit manager. When sent with residents of for an acute change that nursing staff shopy of medications notification. RN #1 swith the resident shoursing note. RN #1 nurses were suppose care plan goals. RN aware of that. On 11/14/19 at 4:27 Administrator and A Nursing were made No further informatio exit.	(complete blood count) and blic panel). Placed on 02 asal cannula) at 2 LPM (liters lled. Transported to (name of 3:30 p.m.) via ambulance" Ince in the clinical record that a plan or care plan goals were not upon transfer to the 17 a.m., an interview was (Registered Nurse) #1, the nasked what documents were upon transfer to the hospital in condition, RN #1 stated could send the face sheet, a stated that documents sent ould be documented in a stated that she wasn't sure if sed to send the care plan or #1 stated that she wasn't 1 p.m., ASM #1, the SM #2, the Director of aware of the above concerns. On could be presented prior to	F 62	22				
	F 625 SS=E	Room of Hospital," of goals or the compression of Bed Hold I CFR(s): 483.15(d)(1	did not address care plan hensive care plan. Policy Before/Upon Trnsfr ()(2)	F 62	25 1.	all readmitted to the facility prior to the			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE A. BUILDING			CONSTRUCTION		E SURVEY IPLETED	
		495392	B. WING			11/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REF	HAB CENTER-WINDERMERE		160	REET ADDRESS, CITY, STATE, ZIP CODE 14 OLD DONATION PKWY RGINIA BEACH, VA 23454	1	TWEUIS
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	§483.15(d)(1) Notice nursing facility transithe resident goes of nursing facility must the resident or residence of the resident or residence of the resident of the any, during which the return and resume of acility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing facility of the periods, we paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed-the time of transfer the specifies the duration of the section or the facility must provide resident represental specifies the duration described in paragraph by: Based on staff internal facility document facility document facility document facility document facility document facility and/or the resident represental specifies the duration described in paragraph by: Based on staff internal facility document facili	ce before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the it provide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing a large payment policy in the state to of this chapter, if any; illity's policies regarding which must be consistent with this section, permitting a land in specified in paragraph (e)(1) thold notice upon transfer. At of a resident for the resident and the lative written notice which on of the bed-hold policy eaph (d)(1) of this section. The is not met as evidenced review, notation review, the facility staff of 38 residents in the survey resident representative, a lice when discharged to the #4, #45, #12, #55).	Fe		 All residents discharged from the facility are at risk when bed hold information is not provided. Nursing staff will be educated on the process for providing bed hold information to the resident at the time of discharge. Clinical Managers or designee will conduct engoing audits of 100% of discharged resident's charts to ensurate plan summaries are sent at the time of discharge. Results of audits be shared with the QAPI committee. Date of Completion December 27, 2019 	re : will	
	The facility policy tit	led-Life Care-Bod Hold					

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING	i		11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	86	(X5) COMPLETION DATE
F 625	included: Policy Statement: I the resident or residurations of the bed which the resident is resume residence which the residence which the residence which the residence which the resident or Resident or Resident or Resident of transfer; if resident is an another in the provided a 'Notice of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident model of the hold transfer documents 1. Resident #4 was on 10/28/2015. Resident #4 was on 10/2	t is the facility policy to inform lent representative of the I-hold policy, if any, during a permitted to return and when admitted to an acute on therapeutic leave. It is the facility lend to the f	F	625			

NAME OF PROVIDER OR SUPPLIER SENTARIA NURSENIC AND DELIAR CENTER WINDSPILES A. BUILDING COMPLETED B. WING 11/14/201 STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	019
STREET ADDRESS, GIT, STATE, ZIP CODE	
VIRGINIA BEACH, VA 23454	
PREFIX CACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) IPLETION DATE
Continued From page 49 On 11/14/2019 at approximately 1:00 p.m., the Administrator stated, "The bed hold notice was not provided to the resident or resident representative. The nursing staff on Unit 2 have more experience than the nurses on Unit 1 with sending the bed hold notice to the hospital when residents are discharged. The bed hold notice should have been sent to the hospital." The Administrator and Director of Nursing was informed of the finding at the pre-exit meeting on 11/14/2019 at 4:25 p.m. The facility staff did not present any further information about the finding, 2. Resident #45 was admitted to the facility on 7/3/17 and readmitted on 11/9/19 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance, and cervical spinal cord injury. Resident #45's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/30/19. Resident #45's const recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/30/19. Resident #45 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #45 was coded as being totally dependent on one staff member with all ADLs (activities of daily living), except with meals. On 11/13/19 at approximately 10:36 a.m., an interview was conducted with Resident #45. Resident #45 stated that he had recently come back from the hospital. Resident #45 stated that he did not receive bed hold notification at the time of his transfer. Review of Resident #45's clinical record revealed that he was transferred to the hospital on 11/6/19.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP (1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	ODE		1-412013
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;	There was no evide written bed hold not Resident #45 upon 11/6/19. Resident #41/9/19. On 11/14/19 at 10:2 conducted with RN unit manager. Where sent with residents of for an acute change that nursing staff she copy of medications notification. RN #1 swith the resident she nursing note. RN #1 that a bed hold notic upon transfer to the could not be provided. On 11/14/19 at 4:27 administrator and AS Nursing) were made concerns. No further presented prior to expend the sent failure, demensioned as a sessment was an ARD (assessment was an ARD (assessment Resident #12 was compaired in cognitive	nce in the clinical record that ification was sent with transfer to the hospital on 45 returned to the facility on 7 a.m., an interview was (Registered Nurse) #1, the nasked what documents were upon transfer to the hospital in condition, RN #1 stated ould send the face sheet, a nad the bed hold stated that documents sent ould be documented in a was asked to find evidence se was sent with Resident #45 hospital. This information in a was asked to find evidence se was sent with Resident #45 hospital. This information in a ware of the above or information could be kit. It admitted to the facility on the don 11/11/19 with ded but were not limited to the and diabetes. It recent MDS (minimum data is a quarterly assessment with at reference date) of 8/14/19. Indeed as being moderately function scoring 11 out of IMS (Brief Interview for	F	525			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		1604 OLD DONATION PKWY		11/	14/2019
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F 625	Review of Resident that he had been set The following nursin part: "1400 (2:00 confusion911 calle hospital) at 1530 (3 There was no evide written bed hold not Resident #12 upon 11/7/19. Resident #11/11/19. On 11/14/19 at 10:2 conducted with RN unit manager. When sent with residents of an acute change that nursing staff sh copy of medications notification. RN #1 swith the resident shoursing note. RN #1 that a bed hold notic upon transfer to the could not be provided On 11/14/19 at 4:27 administrator and Al Nursing) were made concerns. No further presented prior to expend the courrent diagnos and Alzheimer's disease.	#12's clinical record revealed and to the hospital on 11/7/19. In gnote was documented in p.m.) Resident presented with ed. Transported to (name of 8:30 p.m.) via ambulance" Ince in the clinical record that ification was sent with transfer to the hospital on 12 returned to the facility on 12 returned to the facility on 14 reasked what documents were upon transfer to the hospital in condition, RN #1 stated ould send the face sheet, a stated that documents sent ould be documented in a was asked to find evidence as was sent with Resident #12 hospital. This information in the same of the above er information could be with the same of the above er information could be and readmitted on 10/10/19. Its included: Hypercalcemia	Fe	625			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONS	(X3) DATE SURVEY COMPLETED		
		495392	B. WING _			11/	14/2019
		IAB CENTER-WINDERMERE		1604 OL	ADDRESS, CITY, STATE, ZIP CODE D DONATION PKWY IIA BEACH, VA 23454		
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F 625	reference date (ARI resident with a 6 of the Brief Interview findicating Cognitive shows resident as be daily decision making. Review of the clinical note dated 11/04/19 that the Resident's I room and updated at Left via stretcher at that time. No documentation was record which stated written information at the resident and/or upon the above findings Administrator and Data 11/14/19 at approximated that no bed hencoding/Transmitting CFR(s): 483.20(f)(1) Security for the sident in the code accility must encode each resident in the code in the code in the code in the code as sees in the sident in the code accility must encode each resident in the code in the	ment with an assessment D) of 10/17/19, coded the a total possible score of 15 on or Mental Status (BIMS), skills for decision making being severely impaired for ang. all record revealed a nurse's at 12:36 AM which included Daughter was present in the about transfer to the hospital. 8 PM was awake and alert at was observed in the clinical the facility staff provided about the bed hold notice to the resident representative transfer or within 24 hours. were shared with the birector of Nursing (DON) on mately 4:30 PM. The DON hold notice was issued. Ing Resident Assessments of the following information for facility: sment.	F 64		MDS discharge assessment was completed for resident #2. All residents who discharge from the facility are at risk for not having a discharge assessment completed. MDS Team lead will educate the MDSC's on the importance of completing timely discharge assessments.	ne	
	(ii) Annual assessm (iii) Significant chan (iv) Quarterly review	ge in status assessments.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUIL(E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 640	reentry, discharge, (vi) Background (facilis no admission ass §483.20(f)(2) Trans after a facility comp a facility must be cat CMS System inform contained in the MD standard record layer and that passes stated CMS and the State. §483.20(f)(3) Transing 14 days after a facility assessment, a facility encoded, accurate, the CMS System, in (i)Admission assessii) Annual assessmit (ii) Significant correct (v) Significant correct (v) Significant correct (vi) A subset of item reentry, discharge, at (viii) Background (facilitial transmission of does not have an accurate state which has by CMS, in the form approved by CMS.	s upon a resident's transfer, and death. ce-sheet) information, if there sessment. mitting data. Within 7 days letes a resident's assessment, upable of transmitting to the nation for each resident DS in a format that conforms to outs and data dictionaries, andardized edits defined by mittal requirements. Within ity completes a resident's transmit and complete MDS data to including the following: sment. ent. ge in status assessment. cition of prior full assessment. ction of prior quarterly	F	640	4. MDSC's will conduct bi-wee for all discharged residents to ensure a discharge asses completed. The results of the will be shared with the QAP 5. Date of Completion December 2019 4. MDSC's will conduct bi-wee for all discharged residents to ensure a discharge asses completed. The results of the will be shared with the QAP 5. Date of Completion December 2019	x 2 mon ssment t he audit I team.	iths was	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	LTIPLE C	(X3) DATE SURVEY COMPLETED		
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SENTAR		IAB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY GINIA BEACH, VA 23454	<u>11/</u>	14/2019
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	review the facility st discharge assessm 1 of 38 residents (R sample. The findings include The facility staff faile MDS assessment for was discharged from another nursing facility diagnoses for Resident another nursing facilimited to Dislocation Resident #2's last M an Annual Assessm Reference Date of C Brief Interview for M 15 out of a possible impairment. In addi #2 requiring total de transfer, dressing, bextensive assistance hygiene and bed moduling (ADL) care. Review of Resident 07/18/19 read in paranother facility via tr Resident stable upo An interview was con Coordinator #1 on 1 p.m. She reviewed then stated, "Reside another facility on 07 another f	arview and clinical record aff failed to ensure a ent (MDS) was completed for residents #2), in the survey ed: ed to complete a discharge or Resident #2. Resident #2 in the facility and admitted to elity on 07/18/19. The lent #2 included but not in of the right hip. linimum Data Set (MDS) was ent with an Assessment of 1/25/19 coded Resident #2's lental Status (BIMS) scoring a 15 indicating no cognitive tion, the MDS coded Resident pendence of one with pathing and tollet use, a of one with personal obility for Activities of Daily #2's clinical note dated to ansport in a wheel chair. In discharge.	F	640			
	will do a discharge N	IDS assessment right now.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI			TRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		16	804 OLD	ADDRESS, CITY, STATE, ZIP CODE D DONATION PKWY A BEACH, VA 23454	1	14/2019
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F 641 SS=D	On the same day at MDS Coordinator pathe transmission of discharge MDS was discharge out of the A briefing was held Director of Nursing 4:25 p.m. The facility information about the CMS's RAI Version Resident assessment assessment assessment materials and the completed discharge from the frequency of the expected to return to the discharge from the frequency of the discharge of	approximately 4:10 p.m., the resented a validation report of the assessment showing a created on 11/14/19 for a facility on 07/18/19. With the Administrator and on 11/14/19 at approximately ty did not present any further e findings. 3.0 Manual (Chapter 1: Interprete findings). 3.0 Manual (Chapter 1: Interprete findings).	F6	540	2. 4	MDS was corrected in section G to include impairment on one side of upper and lower extremity for residents and include impairment on the survey teat exiting the building. All residents have the potential to affected when MDS assessments not accurate. The MDS Team Leader will educa MDS staff on importance of timely accurate completion of MDS assessments.	lent am pe are	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			E SURVEY	
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	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		16	REET ADDRESS, CITY, STATE, ZIP CODE 04 OLD DONATION PKWY RGINIA BEACH, VA 23454	_[11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 641	The findings included Resident #30 was of on 12/18/15. Diagnincluded but not limit Accident (CVA-strok (weakness on one state of the current Minimula assessment with an (ARD) of 09/09/19 of 15 out of a possible Interview for Mental cognitive impairment Resident #30 require of one with transfer, bathing, toilet use an Daily Living (ADL) of Review of Resident assessment with the (Functional Limitation coded for no impairm or lower extremity. Resident #30's comprevision date of 09/1 with self-care deficit bathing, hygiene dreat to left hemiparesis state resident will continue able with staff assist to manage goals inchands on assist for a continue able with staff assist to manage goals inchands on assist for a continue able with staff assist to manage goals inchands on assist for a continue able with staff assist to manage goals inchands on assist for a continue and continue able with staff assist to manage goals inchands on assist for a continue and continue able with staff assist to manage goals inchands on assist for a continue and continue	riginally admitted to the facility oses for Resident #30 ited to Cerebrovascular se) with left hemiparesis ide of the body). In Data Set (MDS), a quarterly Assessment Reference Date oded the Resident #30 with a score of 15 on the Brief Status (BIMS) indicating no it. In addition, the MDS codeding total extensive assistance dressing, personal hygiene, and bed mobility for Activities of are. #30's quarterly MDS ARD of 09/09/19, under in Range of Motion) was ment to Resident #30's upper orehensive care plan with a 2/19 documented resident - assistance required with ssing and grooming related that is post CVA. The goal: a to assist with ADL care as some of the interventions lude but not limited to provide	F 6	641	 4. MDS will conduct bi-weekly audit 10% of quarterly MDS's X 2 months residents' functional status. The results of the audits will be share QAPI team. 5. Date of Completion December 27 2019 	hs for ne I with	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		AB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	1 11/	14/2019
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F 641	hand to remove her her bed covers. Resident able to move my stroke years aga. An interview was concoordinator on 11/1 a.m. She reviewed ARD of 09/09/19 and have been coded in assessment on Resident #30 for Rollimitations, the MDS coor Resident #30 for Rollimitations, the MDS incorrectly." She sa (limitation) to her left extremity). The MD modify the 09/09/19 section the under furnotion to include linupper and lower ext. A briefing was held to Director of Nursing 4:25 p.m. The facilitinformation about the CMS' RAI Version 3 Resident assessment 1). 1.3 Completion of accurately reflects the Goals: The goal of introduce advances increase the clinical the accuracy and variation and the securacy and variation	In the Administrator and content with the Administrator and form the Administrator and form 11/14/19 at approximately "I with the Administrator and fon 11/14/19 at approximately the Administrator and fon 11/14/19 at approximat	F	641			

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		IAB CENTER-WINDERMERE		1604 O	FADDRESS, CITY, STATE, ZIP CODE LD DONATION PKWY NIA BEACH, VA 23454	11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	((X5) COMPLETION DATE
F 641 F 656 SS=E	interview items. Protechnical experts in requested that MDS improving the tool's accuracy.	oviders, consumers, and other the nursing home care 3.0 revision focus on clinical utility, clarity, and Comprehensive Care Plan	F 6		The care plans for residents #6 and #28 were updated to include		
	§483.21 (b)(1) The faimplement a compresare plan for each resident rights set for §483.10(c)(3), that i objectives and timel medical, nursing, an needs that are ident assessment. The codescribe the following (i) The services that or maintain the resident of the services that under §483.24, §483 provided due to the sunder §483.10, inclustreatment under §48 (iii) Any specialized services provide as a result or recommendations. If findings of the PASA rationale in the resident of the service of the passes	A483.21(b) Comprehensive Care Plans A483.21(b)(1) The facility must develop and Implement a comprehensive person-centered Implement a comprehensive with the Implement a comprehensive with the Implement a comprehensive measurable Implement and timeframes to meet a resident's Implement and psychosocial Implement and psychosocial Implement and psychosocial Implement and psychosocial well-being as Implement a comprehensive parametricable Implement a comprehensive I			anticoagulation use. The care plan resident #47 was updated to include the use of a psychotropic medicatio. The care plan for resident #45 was updated to reflect accurate ADL need. The care plan for resident for resident #31 was updated to include interventions for diabetes. Residents who are receiving antipsychotic or anticoagulation medication, who have a diagnosis or diabetes, or who require assistance with ADL'S are at risk for not having care plan that is person centered. Staff will be educated on what should be included in a comprehensive person centered care plan and the important of the care plan accurately reflecting the resident's current status. A 100 % audit of current resident car plans will be conducted to ensure a person centered care plan is in place for those who are receiving antipsychotic or anticoagulation medication, who require ADL assistance or who have a diagnosis of diabetes. Interdisciplinary team will	eds. nt d d son ce	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
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		1AB CENTER-WINDERMERE		16	REET ADDRESS, CITY, STATE, ZIP CODE 64 OLD DONATION PKWY RGINIA BEACH, VA 23454	11/	<u>14/2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	future discharge. File whether the resider community was associated contact agence entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on staff intered and facility document to develop a compresidents (Resident the survey sample. The findings included Facility policy titled, documented the follestablishment, periopatient-centered plates assure a systematic assessing, planning meeting resident's relative relative trauma-informed if a sestablished goals, timonitored through moutcomes.*	preference and potential for acilities must document acilities must document at's desire to return to the sessed and any referrals to ies and/or other appropriate pose. In the comprehensive care at in accordance with the acth in paragraph (c) of this active active at the facility staff failed entersive care plan for 5 of 38 active active and active active and active act	F	556	conduct weekly audits of 10% of resident care plans X 90 days to ensure it is person centered. Audits result will be shared with QAPt committee. 5. Date of Completion December 27, 2019		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
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		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	ODE	1,17	14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SHOULD	RF	(X5) COMPLETION OATE
1	included but not lim Thrombus of right to Thrombus of right to The current Minimulassessment with an (ARD) of 08/01/19 of a total possible score for Mental Status (Ecognitive impairment coded for the usage section N on the MI follows: Indicate the resident receiving the days, the MDS was anticoagulant for 7 of The review of Resides Sheet (POS) indicate Cournadin was start #6's comprehensive care plan for the use medication. An interview was concordinator #1 on 111:55 a.m. She review than ARD date of orders and her care should have been at created since the remedication Cournad appears we did not plan in place." She anticoagulation care An anticoagulation care p.m., but only created	ited to, Acute Embolism and ower extremity. Im Data Set (MDS) a quarterly Assessment Reference Date oded the resident with a 00 of re of 15 on the Brief Interview BMS), indicating severe at. The residents MDS was a of anticoagulant. The DS under medications read as a number of DAYS the permedication during the last 7 coded for receiving an days. Ident #6's Physician Order ed the original order for ed on 01/31/19; Resident are of an anticoagulation Inducted with MDS 1/13/19 at approximately ewed Resident #6's, MDS 08/01/19, current physician plan. When asked if there in anticoagulation care plan sident was taking the in, she replied, "Yes, it out an anticoagulation care said, "I will develop an	F	556			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VOLARI	7101	LE COMPTE LETTE		<u>. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			44/	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REH	HAB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		14/2019
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) AF	(X5) COMPLETION DATE
	anticoagulation care to following informa adverse bleeding re /Coumadin use to m Vein Thrombus (DV prevent and prompt over the next review interventions to mar limited to: give medi- bruising or bleeding signs and symptoms quarterly in care pla and to make physici results and complain A briefing was held w Director of Nursing of 4:25 p.m. The facili information about th 2. Facility staff failed of daily living) function feeident #45. Resident #45 was ac 7/3/17 and readmitte that included, but we dementia without be cervical spinal cord i recent MDS (Minimu was an annual asses	m. The review of the plan included but not limited tion: Resident is at risk for elated to anticoagulant nanage a diagnosis of Deep T - blood clot). Goal: to liv detect and report bleeding to period 1/10/20. Some nage goal include but not lication as ordered, report to charge nurse, monitor for s (s/s) of bleeding, review ns, monitor labs as ordered an aware of abnormal lab lab. With the Administrator and lab lab. With the Administrator and lab lab. With the Administrator and lab lab. It to develop an ADL (activities lab. It is develop and It is an ADL (activities lab. It is	F	\$56			
	#45 was coded as be cognitive function so on the BIMS (Brief Ir exam. Resident #45 dependent on one st (activities of daily livi-	nce date) of 9/30/19. Resident eing moderately impaired in oring 12 out of possible 15 nterview for Mental Status) was coded as being totally aff member with all ADLs ng), except with meals. In					

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/14/2019	
SENTAR		AB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY BINIA BEACH, VA 23454		14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
	Summary, care area Functional/Rehabilit on the assessment. Section B. "Care Plathis care area would Review of Resident plan dated 10/8/19 (ADL status. Review of Resident (Certified Nursing Arevealed that Reside to totally dependent most ADLs. Resider only with meals. On 11/14/19 at 3:19 conducted with OSM MDS nurse. When a under Section B "Ca CAA summary, OSM indicated that that the planned. When aske care planned for Rethat ADL function was to inform staff on horesident care. OSM function was missing plan. OSM #1 stated On 11/14/19 at 4:27 Administrator and ASN Nursing were made 3. Facility staff failed	a "ADL. atation Potential" was triggered A "1" was coded under anning Decision" indicating be care planned. #45's comprehensive care failed to reflect Resident #45's #45's November 2019 CNA ssistant) -ADL tracking form ent #45 was extensive assist on one staff member with at #45 needed supervision p.m., an interview was A (other staff member) #1, the asked what a "one" means are Planning Decision" of the A #1 stated that a "one" iggered area would be care ed if ADL function should be sident #45, OSM #1 stated as typically on every care plan w to provide assistance with #1 confirmed that ADL g from Resident #45's care if, "it's not there."	F	556			

A747-1-1-1-1				_		MR NO	<u>. บย38-บ391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING	i		11/	14/2019
SENTAR		AB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	, 111	142013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Resident #47 was a 7/17/19 with diagno not limited to, Demodisturbance, Alzheir mental disorder and Resident #47's mode Data Set) assessment with an date) of 10/8/19. Rebeing severely impassoring 09 out of polinterview for Mental was coded in Section Score of 00. Reside E0200 (Behaviors) averbal behaviors. Resident #47 was an psychiatric or mood coded in Section N antipsychotic for 7 deak period. Review of Resident (physician order sur Resident #47 was of 1) Olanzapine (Zypr Tablet oral for Ment of Sleep." This orde admission on 7/17/11	admitted to the facility on sess that included, but were entia without behavioral mer's disease with late onset, anxiety disorder. Set recent MDS (Minimum ent was a quarterly ARD (assessment reference esident #47 was coded as aired in cognitive function esible 15 on the BIMS (Brief Status) exam. Resident #47 on D (Mood) as having a mood at #47 was coded in Section as having one episode of esident #47 was coded in agnoses) as having Dementia. ot coded as having any active disorders. Resident #47 was (Medications) as receiving an lays during the seven day look #47's November 2019 POS mary) revealed that in the following medication: exa) (1) 2.5 mg (milligrams) al Disorders Frequency Hour	F	356			
	"Mental Disorder" Review of Resident instructions dated 7/ appropriate diagnosis	#47's hospital discharge 17/19, failed to evidence an is for the use of Zyprexa,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495392	B. WING.		1	1/14/2019
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	DDE	.,,42018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	COMPLETION DATE
F 656	medications which 2.5 mg PO (by mouse Po) (b	have not changedOlanzipine th) TABS (tablets)." #47's comprehensive care nd revised 10/18/19 failed to t #47 was taking an ted behaviors associated with nd an appropriate diagnosis tipsychotic. #47's clinical record failed to rior monitoring. 3 a.m., an interview was (Registered Nurse) #1, the asked if a resident is on a should that medication be a plan, RN #1 stated that all should be addressed on the aff to monitor for targeted cts of the medication etc. rpose of the care plan, RN #1 plan was personalized to	F 6	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	LE CONSTRUCTION	1	LU938-U391 E SURVEY
AND PLAN (DF CORRECTION	IDENTIFICATION NUMBER	A. BUILE	ING			APLETED
		495392	B. WING			11/14/2019	
SENTAR		IAB CENTER-WINDERMERE		10	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		1-112.013
(X4) ID PREFIX TAG	I {EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	behaviors for Resid #4 stated that she was pecific to that persist know to monitor for she would get that is should be documen On 11/14/19 at 4:27 Administrator and A Nursing were made No further informatio (1) Zyprexa "atypical currently in the treat bipolar illness." This from The National Ir https://search.nih.gom/SE2%9C%93&affiliand. For Resident #28 develop a comprehe plan to include anticolor includ	sked if she usually monitors ents on antipsychotics, LPN yould monitor for behaviors on. When asked she would behaviors, LPN #4 stated that information in report and it ited on the care plan. p.m., ASM #1, the SM #2, the Director of aware of the above concerns. On was presented prior to exit. I antipsychotic that is used ment of schizophrenia and information was obtained institutes of Health. Ex/search?ut/8= ate=nih&query=Zyprexa. I, the facility staff failed to ensive person-centered care obagulant medication. Idmitted to the facility on ses included but were not rillation and Diabetes Mellitus. In mum Data Set (MDS - an II) with an Assessment 9/07/2019 was coded with a vof Mental Status) score of initive impairment. In oded Resident #28 as istance of 1 with dressing and itensive assistance of 1 with rand toilet use and total	F	556			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	CODE		142013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	RE .	(X5) COMPLETION DATE
F 656	On 11/14/2019 revise Section N under "M follows: "Indicate the received the following 7 days" The Nanticoagulant for 7 deview of Resident on 11/14/2019 revise MG (Milligram) table Time Daily." Order On 11/14/2019 revise comprehensive care plan for the use of a On 11/14/2019 at a interview was conduted and she was ask anticoagulant?" ME "Yes." When asked resident's care plan and proposed to the care plan and proposed care plan." asked, "What is the MDS Coordinator # know what care to p The Administrator a informed of the finding 11/14/2019 at 4:25 present any further in Definitions: * Xarelto - Xarelto is and Drug Administrator."	ew of Resident #28's MDS in edications Received" read as no number of days the residenting medications during the last MDS was coded for receiving days. #28's Physician Order Sheet aled an order for "Xarelto 20 et 1 tab (Tablet) Oral - One Date: 08/05/2019. ew of Resident #28's et plan did not include a care	Fe	556			

PRINTED: 11/26/2019
FORM APPROVED

074701401		I THE PROPERTY OF THE PERSON O				MB NO). 0938-0391
AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495392	B. WING			1 44	/14/2019
SENTAR		AB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454	1	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	n RE	(X5) COMPLETION DATE
F 656	fibrillation (Afib), de and pulmonary embapproved for condit anticoagulant has becoronary artery disease (PAD Important Safety Inf Xarelto may cause increased risk of bleeding which can death. This is becamedicine (anticoaguelotting. During treafikely to bruise more for bleeding to stop.	ep vein thrombosis (DVT), colism (PE). It is also ions for which no other een approved before, such as ease (CAD) and peripheral b). Cormation: serious side effects, including: serious side effects,	F 6	56			
	develop a comprehe plan to include Diab Resident #31 was a 11/04/2015. Diagno	dmitted to the facility on ses included but were not labetes Mellitus* without					
	assessment protoco Reference Date of 0 BIMS (Brief Interview indicating severe co- addition, the MDS c requiring limited assi dependence of 1 with personal hygiene and	num Data Set (MDS - an I) with an Assessment 9/04/2019 was coded with a v of Mental Status) score of 3 gnitive impairment. In oded Resident #31 as istance of 1 with eating, total in dressing, toilet use, d bathing, and total in bed mobility and transfer.					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	TIPLE CONSTRUCTION			E SURVEY IPLETED
		495392	8. WING			1 44	14/0040
	PROVIDER OR SUPPLIER A NURSING AND REM	IAB CENTER-WINDERMERE		STREET ADDRESS, CITY 1604 OLD DONATION F VIRGINIA BEACH, V	PKWY	1 11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
ſ	On 11/14/2019 revice Physician Order Shrevealed the followith (Milligram)/0.5 ml (injector (0.75 mg) F Subcutaneous Free ICD - 10 E11.9 - Tyle complications." Order Review of Resident person-centered careveal a care plan from 11/14/2019 at 3: conducted with MDS asked if Resident #3 Diabetes Mellitus. "Yes." MDS Coordinates Mellitus withe MDS Coordinater #3 of the care plan is. "It's what we use to the resident." The Administrator at informed of the finding 11/14/2019 at 4:25 present any further in Definitions: * Type 2 Diabetes Myour blood glucose, high. With type 2 diabetes Myour blood glucose, high. With type 2 diabetes Myour blood glucose, high. With type 2 diabetes Myour blood glucose, high.	ew of Resident #31's eet for November 2019 ng: "Trulicity 0.75 mg Milliliter) subcutaneous pen	F	556			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY GINIA BEACH, VA 23454		14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	your cells to give the too much glucose so high blood glucose of with your heart, eyes and teeth.	e that helps glucose get into em energy. Without insulin, tays in your blood. Over time, can lead to serious problems s, kidneys, nerves, and gums	F6	556			
SS=D	* Trulicity - Once we helps your body do naturally-release its your blood sugar ris and exercise to help A1C numbers. Set sugar (hypoglycemia low blood sugar may headedness, confus blurred vision, slurre sweating, hunger, st weakness, anxiety, i Common side effect effects of Trulicity incomiting, abdominal (https://www.trulicity. Care Plan Timing and CFR(s): 483.21(b)(2) \$483.21(b) Compreh \$483.21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an includes but is not lir (A) The attending ph (B) A registered nurs resident.	d Revision)(i)-(iii) nensive Care Plans prehensive care plan must 7 days after completion of assessment. Iterdisciplinary team, that nited to	F 6:	57 1.	revised to include DNR status. The care plan for resident #14 was revis to include monitoring interventions related to a recent incident involving unwanted sexual advances from another resident.	ed I	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING	i		44/44/0040	
	PROVIDER OR SUPPLIER A NURSING AND REH	IAB CENTER-WINDERMERE		16	TREET ADDRESS, CITY, STATE, ZIP CODE 504 OLD DONATION PKWY IRGINIA BEACH, VA 23454	<u> 11/</u>	14/2019
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X6) COMPLETION DATE
F 657	resident. (D) A member of for (E) To the extent prother resident and the An explanation must medical record if the and their resident renot practicable for the resident's care plan (F) Other appropriate disciplines as deternor as requested by (iii)Reviewed and reteam after each assessments. This REQUIREMENT by: Based on staff intereview the facility staff in the review the facility staff in the survey sample, in the findings included the survey sample, in the findings included order. Resident #40 was a 09/17/2019 with diagnot limited to, Chronand Acute Diastolic Resident #40's Minitassessment protocol Reference Date of 0 #40 with a BIMS (Br	od and nutrition services staff. acticable, the participation of a resident's representative(s). It be included in a resident's a participation of the resident appresentative is determined the development of the action and the development of the action are sident's needs the resident. The action are including both the action are including both the action are including both the action and clinical record aff failed to revise the applan for 2 of 38 residents in Residents #40 and #14.	F6	357	 MDS Team leader will educate Interdisciplinary team on the importance of having accurate code status and potential areas for additional monitoring on the resident's comprehensive care plan. A 100% audit on every resident's complan will be conducted to ensure constatus on the resident care plan is accurate. Interdisciplinary team with conduct weekly audits of 10% of resident's care plans X 90 days to ensure it is person centered. Audit results will be shared with QAPI committee. Date of Completion December 27, 2019 	ional are ode	

STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MU A. BUILO	ILTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		495392	B. WING	à		44 0 40 - 4 -
	PROVIDER OR SUPPLIER A NURSING AND REF	HAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	CODE 11	/14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	impairment. In add coded Resident #40 dependence of 1 wi use, personal hygie dependence of 2 wi On 11/13/2019 Res Care Plan was revie following: "(Resided On 11/14/2019 revie Physician Order Shrevealed the following Resuscitate" Order On 11/14/2019 at appropriate of Resident #4 requested and at appropriate of Resident #4 and a "Durable Do 11/06/2019 was reconstructed with the Docare plan should have to "Do Not Resuscitate." Reviewed with the Docare plan should have to "Do Not Resuscitate." The Administrator as informed of the finding 11/14/2019 at 4:25 present any further in 2. For Resident #14 her care plan after si	ition, the Minimum Data Set D as requiring total ith transfer, dressing, toilet ine and bathing and total ith bed mobility. ident #40's Comprehensive ewed and revealed the int Name) is a Full Code." ew of Resident #40's eet For November 2019 ing order: "Do Not Date: 11/06/2019. Disproximately 9:00 a.m., a O's Advance Directives was approximately 11:00 a.m., a O's Advance Medical Directive Not Resuscitate Order" dated eived. Inducted with the Director of 1/14/2019 at 4:00 p.m. and It Resident #40's code status ed, "She has an order for Do esident #40's care plan was ON. The DON stated, "The ve been revised and changed	F	657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495392	8. WING			445	140040	
	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE		1604 OLD DON	ESS, CITY, STATE, ZIP COI NATION PKWY EACH, VA 23454	DE		14/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORR I CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 657	Resident #44 on 8/3 Resident #14 was a 11/14/13 with diagram not limited to demer disturbance and multiple with the second second in the BIMS (Brief I exam. Resident #14 sometimes being unsometimes understawas coded as requirone staff member wand total dependent hygiene. Resident #44 was a 3/23/17 with diagnost limited to Schizophr disorder, anxiety dis Lewy Bodies (1). Re MDS (minimum data quarterly assessment reference date) of 9 coded as being intain 15 out of 15 on the 1 Mental Status) exam requiring limited assember with transfer personal hygiene; at mobility and meals. Review of Resident	admitted to the facility on oses that included but were natia with behavioral ascle weakness. It recent MDS assessment ressment with an ARD assessment with an ARD assessment or many of the property impaired in coring 01 out of possible 15 received for Mental Status). It was coded in Section B as anderstood by staff and anding staff. Resident #14 ring extensive assistance with with bed mobility, and dressing; are on staff with personal. I dmitted to the facility on sees that included but were not received and dementia with resident #44's most recent as set) assessment was a ant with an ARD (assessment /30/19. Resident #44 was cot in cognitive function scoring BIMS (Brief Interview for an Resident #44 was coded as sistance with one staffers, locomotion, dressing, and and independent with bed	F	57				

STATEMENT	OE DESICIENCIES	CAN BOOKER STOLING TO THE				WR NO	<u>. 0938-0391</u>
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING	:		11/14/2019	
		IAB CENTER-WINDERMERE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	1. 111	142013
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE
F 657	"8/30/19: At 21:10 (frantically grabbed tassistant) and aske resident's room to fi #44) face down on tundone. Other resident vinspection; resident vinspection; resident	The following notes were ident #14's chart: 9:10 p.m.) this nurse was by CNA (certified nursing d for my help. I was brought to another resident (Resident to p of her legs with her brief lent was assisted off this	F	357			
	"8/30/19 at 1120 p.n resident (Resident # placing paper object investigated-there v resident's mouth, wl s/s (signs and symp breath) or difficulty bresident appears to either incident. Very confusion. Talking to	n.: 2 staff observed another 44) in wheelchair at bedside tinto her mouth. When was a ten-dollar bill in nich was removed whole. No toms) SOB (shortness of preathing. On examination, have no apparent injury from awake, and alert with the herself, and able to move all co (complaints) of discomfort.					
ľ	plan dated 8/21/19 rewas not revised to re	#14's comprehensive care evealed that her care plan effect this incident with lent #44's care plan was					
	conducted with RN (unit manager. The in part: When asked the a resident on top of a	3 a.m., an interview was Registered Nurse) #1, the Iterview is documented in the process if she were to find another resident with their stated that she would					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495392	B. WING	B. WING			14/2019
SENTAR		IAB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY GINIA BEACH, VA 23454		142013
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	immediately separa	ge 74 te the residents, do an n residents "looking for any	Fe	57			
(84 ° - 25	signs of physical iss would document the as well as the head stated that the care for both residents to between the two respurpose of the care plan was personeeds of each resid care plan should be asked who could restated that any floor plan as well as MDS On 11/14/19 at 4:27	suesRN #1 stated that she incident in a progress notes to toe assessment. RN #1 plan should also be revised alert staff on the incident sidents. When asked the plan, RN #1 stated that the onalized to identify specific lent. RN #1 stated that the revised if needed. When vise the care plan, RN #1 nurse could revise the care S.					
	Nursing) were made concerns. No furthe prior to exit.	SM #2, the DON (Director of aware of the above r information was presented				j	
	associated with abn called alpha-synucle deposits, called Lew the brain whose cha problems with thinki mood. Lewy body decommon causes of was obtained from Thealth. https://www.nia.nih.gmentia#what.	entia "(LBD) is a disease ormal deposits of a protein ein in the brain. These by bodies, affect chemicals in larges, in turn, can lead to lead					
F 677 SS=D	CFR(s): 483.24(a)(2	for Dependent Residents) dent who is unable to carry	F 6	77 1	. Resident #45 fingernaits were trimm prior to survey team exiting the built		
i	3 .3012 ((a)(E) A (63)	dent who is unable to carry					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	VAME OF PROVIDER OR SUPPLIER		B. WING_			11/	14/2019
SENTARA NURSING AND REHAB CENTER-WINDERMERE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	1604 VIRG	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY BINIA BEACH, VA 23454 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N DBF	(X5) COMPLETION DATE
	services to maintair personal and oral hy This REQUIREMEN by: Based on observat interview, clinical redocument review, it staff failed to provid dependent resident survey sample, Res The findings include Resident #45 was a 7/3/17 and readmitte that included but we dementia without be spinal cord injury, as Resident #45's mosset) assessment was an ARD (assessment was ARD (assessment was ARD (assessment was ARD (assessment was an ARD (assessment was cimpaired in cognitive possible 15 on the EMental Status) exambeing totally depend all ADLs (activities of meals. On 11/13/19 at appreciate this nails cut and nails. Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails. When a cown nails, Resident #45 expressible his nails.	y living receives the necessary a good nutrition, grooming, and ygiene; IT is not met as evidenced ion, resident interview, staff cord review and facility was determined that facility e fingernail care for a for one of 38 residents in the ident #45.	F 67	3	assistance with nail care are at risk when nail care is not provided. Nursing staff will be educated on the process for providing resident nail. A 100% audit of all current resident will be conducted to ensure nails at clean and trimmed. Clinical Managor designee will conduct audits of resident's nails 3 x weekly for 4 we then weekly for four weeks, then monthly for 2 months to ensure nail care is being provided. Audit will be shared with QAPI committee with revisions to action plan as needed based on results.	ne care. ts re ger eks,	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		AB CENTER-WINDERMERE		16	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY TRGINIA BEACH, VA 23454	1	14/2018	
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	hands. When asked his nails, Resident is wouldn't do it if he a made of Resident is His nails on both hinch long. Resident the left thumbnail. Review of Resident assistant) -ADL tract that documented "Noblank for the month 2019. On 11/14/19 at 10:2 conducted with Regunit manager. When for providing nail cafingernails, RN #1 snursing assistants) resident was not diafingernails were cut not sure. RN #1 statingernails are long, RN #1 stated that or charge of the resident hat the nurse was a resident refuses nail care. Review of Resident failed to evidence as	move his fingers or open his dif he has asked staff to cut #45 stated that the staff isked. An observation was 45's fingernails at that time. ands were approximately 1/2 #45 had black debris under #45's CNA (certified nursing king form, revealed a section iail Care." This section was sof October and November 0 a.m., an interview was istered Nurse (RN) #1, the nasked who was responsible re including cutting tated that CNA (certified can cut fingernails if the abetic. When asked when that they can also cut nails, werall the floor nurse was in that they can also cut nails. Werall the floor nurse was in that they can also cut nails. Werall the floor nurse was in the care plan the resident frequently #45's care plan dated 10/8/19 my refusals of fingernail care. Ince that Resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the resident #45 had an incention was stated to the care plan the care plan the care plan the care	F	577				
	On 11/14/19 at 10:3	0 a.m., an interview was		- 1				

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STATEMENT AND PLAN (NT OF DEFICIENCIES I OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			111	14/2019
	PROVIDER OR SUPPLIER A NURSING AND REI	IAB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		14/2015
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	assigned to Resider was responsible for stated that nursing a that the aide alerts thails cut. When ask with Resident #45, usually worked with and periodically during the noticed that his stated that she didn't had noticed his toen asked the timeframe Resident #45's toen that she was not surthe first day in two was responsible care, LPN #2, Resident #45's a who was responsible care, LPN #2 stated they will send the resident will send the resident for a resident toenails for a resident stated that nurses can stated that sometimes come in the residents. When ask Resident #45, LPN # been working with Resident working work	A #2, the nursing assistant at #45. When asked who cutting fingernails, CNA #2 aides did not cut any nails, he nurse if a resident needs ed if she frequently worked CNA #2 stated that she Resident #45 on weekends ang the week. When asked if fingernails were long, CNA #2 to notice that day but that she ails were very long. When a (approximately how long) ails were long, CNA #2 stated that day (11/13/19) was reeks she was assigned to be and that day (11/13/19) was reeks she was assigned to be and that day (11/13/19) was reeks she was assigned to be and that day (11/13/19) was reeks she was assigned to be and that day (11/13/19) was reeks she was assigned to be and that day (11/13/19) was reeks she was assigned to be and that doenail that if a resident is diabetic, sident out to podiatry as the heard, did not have an also cut fingernails in an also	F	177			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD			FRUCTION	(X3) DATE SURVEY COMPLETED	
	ME OF PROVIDER OR SUPPLIER					<u> </u>	11/14/2019	
		IAB CENTER-WINDERMERE	<u></u>	160	4 OLD	DDRESS, CITY, STATE, ZIP CODE DONATION PKWY A BEACH, VA 23454		14/2018
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(I CR	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD IOSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	worked with Reside and that day, LPN#; working with Reside notice his fingernality follow this writer to 10:46 a.m., another Resident #45's nails remained to be 1/2 debris underneath the #45 stated at this tire wanted his fingerna. On 11/14/19 at 4:27 staff member) #1, the Director of Nursiabove concerns. Facility policy titled, Grooming, docume "Staff will ensure the Given proper daily princluding skin, nail, at any specific care physician." Provision be documented in the Foot Care CFR(s): 483.25(b)(2) Foot of the consure that reside and care to maintain health, the facility members.	ot. When asked if he had nt #45 the day prior 11/13/19 2 stated that he has been ent #45 but that he did not s. LPN #2 was then asked to Resident #45's room. On observation was made of s. Resident #45's fingernails inch long, this time with no he left thumbnail. Resident me in front of the nurse that he ils cut. p.m., ASM (administrative ne Administrator, and ASM #2, ing were made aware of the "Resident Hygiene and ents in part, the following: at each resident will be: 1, personal attention and care, and oral hygiene, in addition ordered by the attending no faily, personal care will ne clinical record." (2)(i)(ii) care. ents receive proper treatment mobility and good foot		677	2. A	The toenails for resident #45 were trimmed prior to survey team exiting the building All residents who require assistance with nail care on feet are at risk who hail care if not provided.	e en	
	with professional sta to prevent complicat medical condition(s)	andards of practice, including liting			J. of	Staff will be educated on the procestor providing nail care on the feet.) 	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	E CONSTRUCTION		<u>. 0938-0391</u> E SURVEY
Turb I But	or connection	IDENTIFICATION NUMBER:	A. BUILI	DING			PLETED
		495392	B. WING	3		11/	14/2019
SENTAR		AB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		14/2013
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	arranging for transpappointments. This REQUIREMENTH by: Based on observation interview, facility docrecord review, it was failed to provide pooresidents in the survival The findings include Resident #45 was ac 7/3/17 and readmitte that included but we dementia without be spinal cord injury, and Resident #45's most set) assessment was an ARD (assessment was an ARD (assessment Resident #45 was compaired in cognitive possible 15 on the Boundard Status) exambeing totally dependent all ADLs (activities of meals. On 11/13/19 at approinterview was conducted the status of the sident #45 expressible his finger nails cout nails. Resident #45 offer to cut his nails, I may be able to but the sident was able to but the sident was accounted to the sident #45 offer to cut his nails.	is qualified person, and cortation to and from such ortation to and from such on, resident interview, staff cument review and clinical is determined that facility staff diatry services for one of 38 yey sample, Resident #45.	F	687	 A 100% audit of current resident's toenails will be conducted to ensur nails are clean and trimmed and referrals to podiatry services are mas needed. Clinical Manager or designee will conduct audits of resident's nails 3 x weekly for 4 we then weekly for four weeks, then monthly for two months to ensure reare is being provided. Audit will be shared with QAPI committee with revisions to action plan as needed based on results. Date of Completion December 27, 2019 	ade eks,	

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	his hands. When as cut his nails, Reside wouldn't do it if he a made of Resident #His nails on both his inch long. Resident left thumbnail. Resident left thumbnail. Resident responsible for cutti that nursing aides daide alerts the nursing aides daide alerts the nursing worked with Resident #45, CNA worked with Resident #45, CNA worked with Resident #45's toen that she was not sur the first day in two worked with #45's toen that she was not sur the first day in two worked with #45. CNA had just recently that pain. On 11/14/19 at 10:48 conducted with LPN #2, Resident #45's a who was responsible care, LPN #2 stated they will send the residently, from what he facility, from what he facility will send the resident #45's facility, from what he facility, from what he facility will send the residently from what he facility from what he facilit	sked if he has asked staff to ent #45 stated that the staff isked. An observation was 45's fingernails at this time. ands were approximately 1/2 #45 had black debris under ident #45 did not express any toenails at that time. His feet	F	87					

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING AND REP	IAB CENTER-WINDERMERE		10	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	<u> 11/</u>	14/2019	
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	stated that CNAs canon-diabetic resider toenails for a resider stated that nurses of stated that nurses of stated that sometime sometimes come in residents. When as Resident #45, LPN been working with Fapproximately two wonoticed that his toen that he did not. Whe with Resident #45 through the thing toenails. LPN #2 was writer to Resident #45 was writer to Resident #45 be very long and his thickened. At this time complaining that his pain. Resident #45 so long it had been since On 11/14/19 at 4:27 staff member) #1, the DON (Director of the above concern Facility policy titled, documents in part, the sures that podiating patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients and residen will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or obtain by the attending physical patients are siden will provide or	or a diabetic resident. LPN #2 an also cut fingernails in an ant. When asked who cuts nt who is not diabetic, LPN #2 an cut toenails. LPN #2 also es a volunteer group will to do manicures for ked if he frequently works with #2 stated that he has only ew months and that he has lesident #45 for weeks. When asked if he had eails were long, LPN #2 stated in asked if he had worked he day prior 11/13/19 and that hat he has been working with at he did not notice his is then asked to follow this is then asked to follow this is then asked to follow this is toenails were observed to right toe thumbnail was ne Resident #45 was right toenail was causing him stated that he didn't know how ce his toenails were cut. p.m., ASM (administrative e Administrator, and ASM #2, i Nursing) were made aware ins.	F	87				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DAT	E SURVEY
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F 687	personnel means the licensed, certified, composition professional standar minimize complication medical condition (s).	plicable State law. Qualified hat professional staff are or registered to provide es in accordance with and State laws and rds of practice including to ons from the resident's or provide including the construction of the resident's or provident's or provident's or provident including the construction of the resident's or provident including the construction of the resident's or provident including the construction of the c	F6	87			
F 600	(1) Polyneuropathy- "Peripheral neuropathy refers to the many conditions that involve damage to the peripheral nervous system, the vast communication network that sends signals between the central nervous system (the brain and spinal cord) and all other parts of the body." This information was obtained from The National institutes of Health. https://www.ninds.nih.gov/Disorders/Patient-Care giver-Education/Fact-Sheets/Peripheral-Neuropat hy-Fact-Sheet.						
SS=D	CFR(s): 483.25(c)(1) §483.25(c) Mobility. §483.25(c)(1) The faresident who enters range of motion doerange of motion unle condition demonstration of motion is unavoid §483.25(c)(2) A resimple for the faresident further decrease prevent further decrease \$483.25(c)(3) A resident faresident for the faresident	acility must ensure that a the facility without limited s not experience reduction in ess the resident's clinical ttes that a reduction in range	F 6		 The order for the hand splint for resident #44 was discontinued and resident care plan was updated to reflect resident's refusal to wear the splint. All residents who require adaptive equipment to maintain range of mare at risk when the physicians or for the use of the equipment is not followed. Nursing staff will receive education the importance of using adaptive equipment to maintain ROM and process for reporting and document resident refusals. 	e otion der	

		A INCOLOR OF LAIDED			U	MH NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY
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F 688	the maximum pract reduction in mobility This REQUIREMEN by: Based on staff interand clinical record reducitity staff failed to plan of care for the one of 38 residents Resident #44. The findings include Resident #44 was a 3/23/17 with diagnostimited to post stroke Schizophrenia, major dementia with Lewy Resident #44's mos Set) assessment was with an ARD (assess 9/30/19. Resident #44 was consistence with one locomotion, dressing independent with be Resident #44 was consistence with one locomotion, dressing independent with be Resident #44 was consistence with one locomotion, dressing independent with be Resident #44 was consistence with one locomotion, dressing independent with be Resident #44 was consistence with one locomotion of the body (up) Review of Resident Discharge Summary was discharged from	ain or improve mobility with icable independence unless a is demonstrably unavoidable. It is not met as evidenced review, facility document review eview, it was determined that follow physician's orders and application of a hand splint for in the survey sample, dd: dmitted to the facility on ses that included but were not e, muscle weakness, or depressive disorder, and Bodies. trecent MDS (Minimum Data as a quarterly assessment sment reference date) of 44 was coded as being intact scoring 15 out of 15 on the word Mental Status) exam. Each of the word member with transfers, g, and personal hygiene; and d mobility and meals. Each of Section G0400. The shaving impairments to one per and lower). #44's Occupational Therapy revealed that Resident #44 therapy services on 5/9/19. Was documented: "PT"	F	688	 Clinical Manager will conduct a 100 audit of current residents who curred have physician's orders for adaptive equipment to ensure physician's or are being followed. Clinical Managor designee will conduct ongoing at of physician orders to ensure the usadaptive equipment as ordered or documentation of the resident's refix Audits to be conducted 3 x weekly weeks, then weekly for four weeks, then monthly for two months. Audit be shared with QAPI committee with revisions to action plan as needed based on results. Date of Completion December 27, 2019 	ently e ders er udits se of usal. for 4	

AND PLAN	ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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	donning/doffing spliintegrity checks. Dis 24 hour care and Spursing program) n/ Review of Resident (physician order surfollowing active order hand in AM & (and) R/T (related to) conf Review of Resident and revised 10/8/19 "(Name of Resident hand and right side hand." On 11/13/19 at 9:53 1:36 p.m., and 3:00 of Resident #44. Shiplace to her right hand the refused her hand was no evidence in the refused the hand she refused the hand roll. Review of Resident for the refused the hand roll. Review of Resident for the refused the hand roll. Review of Resident for the refused the hand roll. On 11/14/19 at 11:34 conducted with CNA #3, Resident #44's CA #3, Resident #44's CA #3, Resident #44's CA #3, Resident #44's CA #4's CA #4's Resident #44's CA #3, Resident #44's CA #3, Resident #44's CA #4's CA #4's Resident #44's CA #3, Resident #44's CA #4's Resident #44's Re	in education on proper to (sic) and importance of skin scharge Recommendations: clint/braceRNP (restorative a (not applicable). #44's November 2019 POS anmary) documented the er: "Apply hand roll to right take off during evening hours tractures." #44's care plan dated 7/23/19 documented the following: #44) has contracture of right weaknessHand roll to right weaknessHand roll to right a.m., 10:12 a.m., 12:17 p.m., p.m. observations were made a did not have her hand roll in and. Ince in the clinical record that d roll (splint) that day. There Resident #44's care plan that d roll or removed the hand #44's November 2019 TAR ation record) revealed that hand splint was in place	F6	;88 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT		
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	PROVIDER OR SUPPLIER A NURSING AND REM	IAB CENTER-WINDERMERE		10	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY TRGINIA BEACH, VA 23454		14/2019	
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F 688	residents, CNA #3 serestorative, the rest or the assigned nur splints. CNA #3 star restorative for ambiguassigned aide (usus When asked if Resisplint in place on 11 Resident #44 has rethat she stopped of #44. CNA #3 stated 11/13/19 to place he the process if a resisplints, CNA #3 stated if Resident #44 still hand splint. When a aware of any chang as pertinent orders, aware in a verbal reconsident had an actistated that she did replan.	stated that if a resident is on orative aides place the splints sing aide can place the ted that Resident #44 was on plation and that her regular ally CNA #3) places her splint. Ident #44 had her right hand /13/19, CNA #3 stated that refused so much in the past fering to place it on Resident that she did not even offer on ar hand splint. When asked dent continues to refuse hand red that she would alert the red that she was not even sure had an active order for the resked how CNAs are made residents status such CNA #3 stated she is made port, that she did not have a rece to check to see if a ve order for splints. CNA #3 not have access to the care	F	888				
	conducted with a nu (Licensed Practical was responsible for place, LPN #4 state nurses responsibility place per physician' nursing aides may be depending on the or nursing aides were needs to be put on a it should be on the A chart for that specifi	O a.m., an interview was urse on the unit, LPN Nurse) #4. When asked who ensuring splints were in d that it was ultimately the y for ensuring splints are in s order. LPN #4 stated that we able to place a splint order. When asked how made aware that a splint a resident, LPN #4 stated that a splint control of the control						

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		14/2019
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE I	(X5) COMPLETION DATE
	how to care for each the ADL guides were On 11/14/19 at 11:4 chart dated 11/2019 hand splint. On 11/14/19 at 11:5 conducted with RN unit manager. Whe for ensuring a splint order, RN #1 stated nursing aides were at the nurse was ultimated that a splint splint order at the nurse was ultimated that if a resident refuse clearly document care planned if refuse stated that frequent order needs to be clearly document order needs to be cle	h resident. LPN #4 stated that e kept at the nurses station. 5 a.m., Resident #44's ADL of did not address her right 6 a.m., an interview was (Registered Nurse) #1, the on asked who was responsible was in place per physician's that she was not sure if able to place splints, but that ately responsible. RN #1 int should be on if there is a rot to be on. RN #1 stated uses to wear a splint, it must ted in the clinical record and sals are frequent. RN #1 refusals may indicate that the hanged. RN #1 stated that with Resident #44. In eximately 2:00 p.m., an incred with LPN #2, Resident asked who was responsible to on residents, LPN #2 on in the morning if she lets if she was wearing her hand PN #2 stated that if the TAR (treatment d) that she was wearing it told LPN #2 about the above at her assigned CNA did not int, LPN #2 stated that his	F 68			
	uccumentation on th	e November TAR must have		1		- 1

STATEMENT	T OF DEFICIENCIES	(74) 556145555516541654				OMB NO. 0938-039	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		495392	B. WING	i		11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		160	REET ADDRESS, CITY, STATE, ZIP CODE 04 OLD DONATION PKWY RGINIA BEACH, VA 23454	1 11/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE
F 688	splint, LPN #2 state	ge 87 Vhen asked if he placed her d that he did not. LPN #2 also t #44 did not put her splint on	F€	588			
F 758 SS=D	staff member) #1, the Director of Nurs above concerns. A f but not received. Free from Unnec Ps	p.m., ASM (administrative ne Administrator, and ASM #2, ing were made aware of the acility policy was requested sychotropic Meds/PRN Use ()(e)(1)-(5)	F7	'58	The psychotropic medication for Resident #47 was reviewed by the		
Ç.	affects brain activitied processes and behalf	chotropic drug is any drug that es associated with mental vior. These drugs include, o, drugs in the following			attending physician. 2. All residents who are receiving psychotropic medication are at potential risk for receiving unnecess medication. 3. Nursing staff will be educated on the need for a proper diagnosis for the of psychotropic medications. 4. Clinical Manager or designee will conduct a 100% audit of all current	sary	
	§483.45(e)(1) Reside psychotropic drugs a unless the medication as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventions.	ents who have not used are not given these drugs an is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and			residents who are receiving psychotropic medication to ensure there is a proper diagnosis for the u of the medication. All new admissions and current residents who are receipsychotropic medication will be discussed at the weekly resident at meetings to determine if there is a proper diagnosis for the use of the medication. Facility will follow pharmacy consultant recommendation regarding gradual dose reductions.	ions ving risk	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	C	(X3) DATE SURVEY COMPLETED	
		495392	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			11/	14/2019
SENTAR	<u> </u>	AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	OE S		1-72010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 758	§483.45(e)(3) Resigns psychotropic drugs unless that medicat diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 day §483.45(e)(5), if the prescribing practitio appropriate for the I beyond 14 days, he rationale in the resignidicate the duration §483.45(e)(5) PRN	dents do not receive pursuant to a PRN order ion is necessary to treat a condition that is documented i; and orders for psychotropic drugs ys. Except as provided in attending physician or ner believes that it is PRN order to be extended or she should document their dent's medical record and of for the PRN order.	F7	Results of audit will be share QAPI committee. 5. Date of Completion Decemb 2019			
	drugs are limited to renewed unless the prescribing practitio the appropriateness. This REQUIREMEN by: Based on staff inter and facility document that facility staff faile sampled residents, unnecessary psychology are findings included. Resident #47 was a 7/17/19 with diagnost limited to Dementia disturbance, Alzhein mental disorder and #47's most recent Massessment was a control of the prescription.	14 days and cannot be attending physician or ner evaluates the resident for of that medication. IT is not met as evidenced view, clinical record review at review, it was determined to ensure one of 38 Resident #47, was free from otropic drugs. d: dmitted to the facility on sees that included but were not attended.					

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING AND REI	1AB CENTER-WINDERMERE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	11/	14/2019
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) B.F.	(X5) COMPLETION DATE
	impaired in cognitive possible 15 on the 14 Mental Status) exart Section D (Mood) at Resident #47 was of (Behaviors) as having behaviors. Resident (Active Diagnoses) #47 was not coded psychiatric or mood coded in Section Not antipsychotic for 7 of back period. Review of Resident (physician order surface) Resident #47 was of 15 Olanzapine (Zypromotion Tablet oral for Mental Disorder Resident #47's clinical "Mental Disorder Review of Resident instructions dated 7 pappropriate diagnos following was documedications which hold 2.5 mg PO (by mouth Review of Resident plan dated 8/6/19 arreflect that Resident antipsychotic use and section 15 on the 16 page 16	efunction scoring 09 out of BIMS (Brief Interview for m. Resident #47 was coded in shaving a mood score of 00. Toded in Section E0200 and one episode of verbal to #47 was coded in Section I as having Dementia. Resident as having any active disorders. Resident #47 was (Medications) as receiving an days during the seven day look #47's November 2019 POS mmary) revealed that in the following medication: Texa) (1) 2.5 mg (milligrams) all Disorders Frequency Hour rewas initiated upon 19. There was no evidence in cal record indicating what esident #47 had. #47's hospital discharge /17/19, failed to evidence and is for the use of Zyprexa. The mented: "Continue these have not changedOlanzipine th) TABS (tablets)." #47's comprehensive care and revised 10/18/19 failed to	F7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER A NURSING AND REF	IAB CENTER-WINDERMERE	1	16	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY IRGINIA BEACH, VA 23454	<u> 11/</u>	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N BE RIATE	(X5) COMPLETION DATE	
	Resident #47's clinical any behavior monitor reports since August irregularities. On 11/14/19 at 10:1 conducted with RN unit manger. When resident is admitted anti-psychotic media resident is admitted anti-psychotic, nursidiagnosis is attached that an AIMS (abnor scale) assessment and termine if the resident's baseline. Staff should "Do a determine if the resident's baseline. Staff should "Do a determine if nursident's baseline. Staff should "Do a determine if nursident's behaviors or any tarthe anti-psychotic, Foursing unit has behaved in resident who is #1 stated that behaved a resident is exhibiting a resident is on a psymedication should be RN #1 stated that all	cal record failed to evidence bring. #47's monthly pharmacy at 2019, revealed no 3 a.m., an interview was (Registered Nurse) #1, the asked the process if a to the facility on an eation, RN #1 stated that if a to the facility on an ing will first ensure a proper d to the order. RN #1 stated mal involuntary movement will also be completed to dent is presenting with any ats from the use of if these side effects are the RN #1 stated that nursing eeper dive to see how long en on an anti psychotic." ing should monitor for geted behaviors for the use of the way and monitoring sheets for son psychotropic drugs. RN viors should be documented if ng a behavior. When asked if ychotropic drug, if that e reflected on the care plan, I psychotropic drugs should a care plan to alert staff to	F	758			
	medication etc. Whe of "Mental Disorder" this diagnosis should	m asked what the diagnosis means, RN #1 stated that be clarified. RN #1 stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUILD	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING AND REF	AB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, 2 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		<u>11/</u>	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TIX (EACH CORRECTIVE ACT	TION SHOULD	BE	(X5) COMPLETION DATE
F 758	stated that there ha the use of an anti-picknew why Resident stated that she was and was not sure. Find why Resident #47 which was not aware of an stated that she was monitor for any type #47. Stated that there has a stated that she was monitor for any type #47. Stated that there has a stated with LPN #4, Resident #47 stated	ge 91 s to be a specific diagnosis for sychotic. When asked if she #47 was on Zyprexa, RN #1 not familiar with Resident #47 lN #1 was asked to find out was on Zyprexa and any sheets she could find. 5 a.m., further interview was #1. RN #1 presented a sheet dated 11/2019 that owing targeted behavior stated that she still could not dent #47 was on Zyprexa. Resident #47's delusions were, dn't know. "zeros" were behavior monitoring sheet dent #47 did not have any ber so far. When asked about r behavior monitoring sheets, build only find November so a.m., an interview was a (certified nursing assistant) requent CNA. When asked if shibited any behaviors since #3 stated that maybe one ollered at friends visiting but y other behaviors. CNA #3 not aware that she had to of behaviors for Resident 6 a.m., an interview was (Licensed Practical Nurse) requent nurse. When asked if xhibited any behaviors, LPN times Resident #47 was	F	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED		
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SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	DDE	11/	14/2019	
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	worried when she dabout her care, but #47 had anxiety. LP confused about a trushe gets all the ansi Resident #47 was ta she was not sure which was not aware to any targeted/specific she usually monitors antipsychotics, LPN monitor for behavior When asked she we behaviors, LPN #4 sinformation in report on the care plan. On 11/14/19 at 11:53 rest of Resident #47 August 2019 through the behavior monitor Resident #47 had not not 11/14/19 at 12:56 conducted with ASM member) #3, Residemedical director. Whas taking Zyprexa, discharged from the ASM #3 checked the with this writer and for 2018, Resident #47 medication (not in the to her recent hospital that Resident #47 walong period of time a not see a reason to comeone started her	idn't understand something she wouldn't say Resident (N #4 stated, "It's more if she's eatment she harps on it until wers." When asked why aking Zyprexa, LPN #4 stated by she was on Zyprexa and that she had to monitor for to behaviors. When asked if is behaviors for Residents on #4 stated that she would so specific to that person. Fould know to monitor for stated that she would get that and it should be documented and it should be documented for a.m., RN #1 presented the she behavior monitoring sheets in October 2019. Review of ring sheets revealed that to delusions. Dip.m., an interview was a (administrative staff and #47's physician and the nen asked why Resident #47 ASM #3 stated that she was hospital on the medication. It is hospital computer system bound that between 2017 and	F 7	58				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				re Survey MPLETED
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	PROVIDER OR SUPPLIER A NURSING AND REF	AB CENTER-WINDERMERE		1604 C	T ADDRESS, CITY, STATE, ZIP CODE DLD DONATION PKWY INIA BEACH, VA 23454		/14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 758	monitoring Residen Resident #47 had d deficits, but it was h were because she he behaviors. ASM #3 medication, whatever admission may commess with it?" ASM (name of a psych gramment of a psych gramment was the psych gramment of the familiant she was taking the medication. ASM #3 also talk to the familiant she was taking the diagnosis of "Me #3 stated that that danything, such as deficited in the diagnosis of anything, such as deficited in the diagnosis of anything in the diagnosis of any	t #47 for, ASM #3 stated that ementia and some memory and to say what her behaviors hadn't displayed any stated that if they stopped the er behaviors she had prior to be back. ASM #3 stated, "Why #3 stated that he could get roup) to come in and evaluate at it was hard to get psych as ASM #3 then stated that oup should come in if there o why she was taking the a stated that maybe he could by to see if anyone knew why medication. When asked what ental Disorder" means, ASM liagnosis could mean epression.	F7	758			
	Nursing were made The AIMS assessmethis writer for Reside No further information A facility policy could (1) Zyprexa "atypica currently in the treat bipolar illness." This from The National Ir https://search.nih.go %E2%9C%93&affilia	SM #2, the Director of aware of the above concerns. ent could not be provided to ent #47. On was presented prior to exit. If not be provided. If antipsychotic that is used ment of schizophrenia and information was obtained institutes of Health. Dev/search?utf8= ate=nih&query=Zyprexa.					
F 842 SS=D	Resident Records - CFR(s): 483.20(f)(5)	Identifiable Information), 483.70(i)(1)-(5)	F 8	42 1.	The LPN was educated on the importance of accurate documer in a resident clinical record.	tation	

STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILC		(X3) DATE SURVEY COMPLETED		
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ŀ	PROVIDER OR SUPPLIER A NURSING AND REF	HAB CENTER-WINDERMERE		1604	ET ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY GINIA BEACH, VA 23454	111/	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI OEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	§483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extent to do so. §483.70(i) Medical of §483.70(i)(1) In accordessional standar must maintain medit that are- (ii) Complete; (iii) Accurately docur (iii) Readily accessif (iv) Systematically of §483.70(i)(2) The facall information contaregardless of the for records, except where (ii) To the individual, representative where (ii) Required by Law (iii) For treatment, properations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement purposes, research medical examiners, a serious threat to health neglect.	ent-identifiable information. release information that is to the public. release information that is to an agent only in contract under which the agent r disclose the information the facility itself is permitted records. ordance with accepted rds and practices, the facility cal records on each resident mented; ble; and irganized cility must keep confidential ained in the resident's records, m or storage method of the en release is- or their resident e permitted by applicable law; cayment, or health care itted by and in compliance	F	3	2. All residents are at risk when the clinical record is inaccurate 3. Nursing staff will be educated on the importance of proper documentation reflect an accurate clinical record to include the use of adaptive equipments. Clinical Manager or designee will conduct ongoing audits of treatment orders 3x weekly x two weeks, week x two weeks, then monthly x two months to ensure accurate documentation of adaptive equipments. Audits results will be shared with Quality committee and revised as needed. Date of Completion December 27, 2019	n to cent. t kly	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	HAB CENTER-WINDERMERE		S 10	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	1 11/	/14/2019
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	IX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	2 Continued From page 95		F	842			
	§483.70(i)(3) The farecord information a unauthorized use.	acility must safeguard medical against loss, destruction, or					
	§483.70(i)(4) Medic for-	cal records must be retained					
	(i) The period of tim (ii) Five years from there is no requirem	ne required by State law; or the date of discharge when nent in State law; or years after a resident reaches ate law.					
	(i) Sufficient informa (ii) A record of the re (iii) The comprehend provided;	nedical record must contain- ation to identify the resident; resident's assessments; nsive plan of care and services					
	(iv) The results of an and resident review determinations cond (v) Physician's, nurs professional's progressional's progressio	ducted by the State; se's, and other licensed ress notes; and					
	(vi) Laboratory, radio services reports as This REQUIREMEN by:	iology and other diagnostic required under §483.50. NT is not met as evidenced					
	document review, as was determined that	tions, staff interview, facility and clinical record review, it at facility staff inaccurately ne of 38 residents (Resident and roll/splint in use.					
	The findings include	ed:					
	3/23/17 with diagnos limited to post stroke	admitted to the facility on uses that included but were not se, muscle weakness, or depressive disorder, and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	· ·	495392	B. WING			11/	14/2019
NAME OF PROVIDER OR SUPPLIER SENTARA NURSING AND REHAB CENTER-WINDERMERE				10	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	dementia with Lewy Resident #44's mosset) assessment was an ARD (assessme Resident #44 was a cognitive function of BIMS (Brief Intervier Resident #44 was a assistance with one locomotion, dressin independent with be Resident #44 was a (Functional status) as ide of the body (up Review of Resident Discharge Summan was discharged from The following in part (patient) and careginate engivers engaged donning/doffing split integrity checks. Dis 24 hour care and Spnursing program) n/ Review of Resident (physician order surfollowing active order hand in AM & (and) R/T (related to) control Review of Resident and revised 10/8/19 "(Name of Resident and Resident Re	st recent MDS (minimum data as a quarterly assessment with as a quarterly assessment with at reference date) of 9/30/19. The coded as being intact in coring 15 out of 15 on the work for Mental Status) exam. The coded as requiring limited a staff member with transfers, g, and personal hygiene; and the coded is Section G0400. The coded is	F8	142			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
		495392	B. WING	3			14/0040
	PROVIDER OR SUPPLIER A NURSING AND REI	HAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, ZI 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		<u> 11/</u>	14/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACT	TON SHOULD THE APPROP	BE	(X5) COMPLETION DATE
F 842	On 11/13/19 at 9:53 1:36 p.m., and 3:00 of Resident #44. Shroll/splint in place to There was no evide she refused her har was no evidence in she refused the har roll. Review of Resident (treatment administ Resident #44's nurs Resident #44's right during the day shift On 11/14/19 at 11:5 conducted with RN unit manager. Whe for ensuring a splint order, RN #1 stated nursing aides were the nurse was ultimiconfirmed that a spl physician's order for that if a resident refuse clearly document care planned if refusitated that frequent order needs to be of she was not familiar. On 11/14/19 at 11:3 conducted with CNA#3, Resident #44's (responsible for puttiresidents, CNA #3 sesidents, CNA #3 sesidents.	a.m., 10:12 a.m., 12:17 p.m., p.m. observations were made to did not have her hand other right hand. Ince in the clinical record that and roll (splint) that day. There Resident #44's care plan that and roll or removed the hand #44's November 2019 TAR ration record) revealed that the hand documented that thand splint was in place on 11/13/19. 6 a.m., an interview was (Registered Nurse) #1, the en asked who was responsible was in place per physician's that she was not sure if able to place splints, but that ately responsible. RN #1 int should be on if there is a r to to be on. RN #1 stated uses to wear a splint, it must ted in the clinical record and sals are frequent. RN #1 refusals may indicate that the hanged. RN #1 stated that	F	842			

AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	(X3) D	ATE SURVEY OMPLETED
Ø .		495392	B. WING	.	1	1/14/2019
SENTAR		IAB CENTER-WINDERMERE		STREET ADDRESS, CITY, STATE, 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 2345	ZIP CODE	11112013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OTION SHOULD BE OTHE APPROPRIATE	COMPLETION DATE
F 842	or the assigned nur splints. CNA #3 stat restorative for ambit assigned aide (usus When asked if Resisplint in place on 11 Resident #44 has rethat she stopped of #44. CNA #3 stated 11/13/19 to place hethe process if a resisplints, CNA #3 stated from the process if a resisplints, CNA #3 stated from the process if a resisplints, CNA #3 stated from the fr	ge 98 sing aide can place the sed that Resident #44 was on plation and that her regular ally CNA #3) places her splint. Ident #44 had her right hand /13/19, CNA #3 stated that refused so much in the past fering to place it on Resident that she did not even offer on er hand splint. When asked dent continues to refuse hand ed that she would alert the red that she was not even sure had an active order for the resked how CNAs are made residents status such CNA #3 stated she is made port, that she did not have a rece to check to see if a	F	842		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495392	B. WING	.		11/	14/2019	
	PROVIDER OR SUPPLIER IA NURSING AND REF	HAB CENTER-WINDERMERE		10	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	<u> </u>	14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(XS) COMPLETION DATE	
F 842	address her right had on 11/14/19 at apprinterview was condut #44's nurse. When for placing and splir stated that the CNA asked about Reside stated, "CNAs put it them." When asked splint on 11/13/19, Laure if she was weathe documented on administration recort then she was. When observations and the offer to place the special documentation on the been an accident. Wasplint, LPN #2 stated that Resident herself. When asked document that a treadministered when it don't know, should it would find out. On 11/14/19 at 4:27 staff member) #1, the DON (Director of the above concerned.)	chart dated 11/2019, did not and splint. roximately 2:00 p.m., an ucted with LPN #2, Resident asked who was responsible nts on residents, LPN #2 As will put on splints. When ent #44's hand splint, LPN #2 t on in the morning if she lets d if she was wearing her hand LPN #2 stated that if	F	B42				

			(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED			
		495392	B. WING				11/	14/2019
NAME OF PROVIDER OR SUPPLIER SENTARA NURSING AND REHAB CENTER-WINDERMERE				160	REET ADDRESS, CITY, STATE, ZIP CO D4 OLD DONATION PKWY RGINIA BEACH, VA 23454	OE.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	8E	(XS) COMPLETION DATE
F 880 F 880 SS=D	Infection Preventior CFR(s): 483.80(a)(i) §483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the folio §483.80(a)(1) A system of survival and communicable staff, volunteers, vis providing services arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the post are not limited to (i) A system of survival possible communication infections before the persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and training the	in & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at awing elements: Item for preventing, identifying, ing, and controlling infections diseases for all residents, sitors, and other individuals upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, be eillance designed to identify able diseases or ey can spread to other		380	 The LPN caring for resident educated on proper handwaprocedures prior to surveyor the building. Resident #321 monitored for signs and syninfection with no adverse out noted. All residents receiving blood monitoring procedures are aproper hand hygiene is noted. Licensed nursing staff will be on proper hand washing produring blood sugar monitoring. The clinical manager or desconduct visual observations week x 8 weeks of licensed staff to ensure proper infect practices are being maintain blood sugar monitoring proceduit results will be shared QAPI team and any further observations of improper infection of the action placetices. Date of Completion December 2019 	ashing rs exiting was nptoms twas nptomes d sugar at risk w followed e educa ecedure ng. ignee w i 3 x per nursing ion confi ed duri ecedures with the fection n a an	of s when d. ated es vill r g trol ing	

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495392	B. WING	í			••••
	PROVIDER OR SUPPLIER A NURSING AND REF	AAB CENTER-WINDERMERE		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454	<u>l 11/</u>	<u>/14/2019</u>
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 880	(iv)When and how is resident; including to the type and dudepending upon the involved, and (B) A requirement the least restrictive post circumstances. (v) The circumstance must prohibit emploid disease or infected a contact with resident contact will transmit (vi)The hand hygien by staff involved in contact will transmit (vi)The hand hygien by staff involved in contact will transmit (vi)The hand hygien by staff involved in contact will transmit (vi)The hand hygien by staff involved in contact will transmit (vi)The hand hygien by staff involved in contact will transmit (vi)The hand hygien actions ta staff failed under the corrective actions ta staff failed to hygiene after removing transport lines and the surving transport in the surving the findings included On 11/13/2019 at 4:3	solation should be used for a put not limited to: pration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the ses under which the facility yees with a communicable skin lesions from direct the disease; and e procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the lacility's IPCP and the lacility's the facility. Idle, store, process, and is to prevent the spread of eview. But an annual review of its eir program, as necessary. T is not met as evidenced ons and staff interview the perform appropriate handing dirty gloves for 1 of 38 ey sample (Resident #321).	F	880			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495392	B. WING			11/	14/2019
SENTAR		IAB CENTER-WINDERMERE		16	TREET ADDRESS, CITY, STATE, ZIP CODE 804 OLD DONATION PKWY IRGINIA BEACH, VA 23454		14/20 18
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE
F 880	gloves and remove	a glucometer and blood	F8	180			
	#6 and the Surveyor oom and LPN #6 c Resident #321 and sample with the glut the medication cart removed her dirty ghygiene with hand s gloves. LPN #6 obt the container and cl #6 removed her dirty gloves. LPN #6 fails after removing her cinsulin into a syringe #321's bedside and Resident #321. LPI medication cart, dispersion of the surveyor that the sur	rentered Resident #321's obtained a blood sample from checked the resident's blood cometer. LPN #6 returned to with the glucometer. LPN #6 loves, performed hand anitizer and applied clean ained germicidal wipes from eaned the glucometer. LPN y gloves and applied clean ed to perform hand hygiene dirty gloves. LPN #6 drew up e and went back to Resident administered the insulin to N #6 went back to the posed of the insulin syringe rty gloves and performed and sanitizer.					
	conducted with LPN were reviewed with LPN #6 was asked to you removed your dapplied your clean g know." The Survey have performed han	what should have done after inty gloves and before you loves? LPN #6 stated, "I don't or asked LPN #6, "Should you do hygiene after removing if prior to applying the clean					
F 921	informed of the findi 11/14/2019 at 4:25 p present any further i	nd Director of Nursing was ng at the pre-exit meeting on o.m. The facility staff did not nformation about the finding. itary/Comfortable Environ	F9	21			

STATEMENT OF DEFICIENC'ES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBERS		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		(X3) DATE SURVEY		
		BENTINGATION NOMBER:	A. BUILD	A. BUILDING		COMPLETED	
		495392	B. WING			11/	14/2019
SENTAR		AB CENTER-WINDERMERE		18	TREET ADDRESS, CITY, STATE, ZIP CODE 304 OLD DONATION PKWY IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	The facility must prosanitary, and comforesidents, staff and This REQUIREMEN by: Based on observat facility staff failed to environment in the I affect most of the 3s survey sample. The findings include On 11/13/2019 at 11 were observed prepmetal sink which is I table and tray line cobserved on the pip On 11/13/2019 at 1: observed cob webs the metal sink in the asked the Dietary Manage to clean the pipes." asked if cob webs sithe sink? The Dietary Manager staunder the sink and cleaning schedule a schedule. The Administrator ar	avironmental Conditions by de a safe, functional, artable environment for the public. IT is not met as evidenced ions and staff interview the provide a sanitary kitchen which could potentially current residents in the ed: 1:30 a.m., while dietary staff taring lunch trays, under the located next to the steam by webs and dust was es. 05 p.m., the Surveyor and dust on the pipes under kitchen. The Surveyor anager, "What do you see?" er stated, "I will get someone The Dietary Manager was hould be on the pipes under y Manager stated, "No, I will in the pipes now." The ited that cleaning the pipes counter was not on the ind would have to add it to the	F	921	 The cobwebs under the sink were cleared by kitchen staff prior to the survey team exiting the building All residents are at risk when a san environment is not maintained Dietary staff will receive education of cleaning procedures to include locations under the sink. Administrator or designee will perform weekly audits x 8 weeks of the kitch cleanliness to include areas under the sink. Results of the audits will be shared with the QAPI team and reviational needed. Date of Completion December 27, 2019 	on rm nen he	
j	11/14/2019 at 4:25 p	ng at the pre-exit meeting on .m. The facility staff did not nformation about the finding.					

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	0: 11/26/2019	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	APPROVED 0. 0938-0391	
AND PLAN C	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED		
		495392	B. WING			** ***	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	/14/2019	
SENTAR	A NURSING AND REI	HAB CENTER-WINDERMERE		1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(XS) COMPLETION DATE	
		ii.					
22.							