STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING AND REHAB CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/12/19 through 11/14/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 11/12/2019 through 11/14/2019. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. No complaints were investigated during the survey. The census at this 90 certified bed facility was 74 at the time of the survey. The survey sample consisted of 35 current resident reviews and 3 closed records reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584	1. The wheelchairs for residents #6 and #27 were repaired prior to survey team exiting the building. 2. All residents with mobility equipment are at risk when a sanitary and homelike environment is not maintained. 3. Staff in all departments will be educated on completing work orders for equipment that is broken or in need of repair.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Whitenack	Administrator	12/6/19

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

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation, the facility staff failed to maintain a clean, sanitary and homelike environment for 2 of 38 residents (Resident #6 and #27) in the survey sample. The findings included: 1. For Resident #6, the wheel chair was observed with worn, torn and cracked armrest pads. Resident #6 was admitted to the facility on 12/18/15. Diagnoses for Resident #6 included	F 584	4. Maintenance staff will conduct a 100% audit of all current facility wheelchairs to ensure they are clean and in good working order. Maintenance will conduct audits of wheelchairs and mobility equipment once a quarter to ensure equipment is in good working order. Administrator or designee will review completed work order reports weekly to ensure broken equipment is being reported and repaired. Audit results will be shared with QAPI committee. 5. Date of Completion December 27, 2019	

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F 584	Continued From page 2 but not limited to, Dementia with behavioral disturbances. The current Minimum Data Set (MDS), quarterly assessment with an Assessment Reference Date (ARD) of 08/01/19 coded the resident with a 00 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #6 requiring total dependence of one hygiene and bathing, extensive assistance of two with bed mobility and transfer, extensive assistance of one with dressing and toilet use. The MDS was coded under section G 0600 (mobility devices) was coded for wheel chair usage. On initial tour of the facility on 11/12/19 at approximately 11:32 a.m., Resident #6 was observed lying in bed. Resident #6's wheel chair was observed with worn, torn and cracked armrest pads. On 11/13/19 at approximately 10:09 a.m., Resident #6 was observed in the day lounge sitting in her wheel chair. The wheel chair armrest pads to Resident #6's wheel chair remains unchanged; worn, torn and cracked. On the same day at approximately 10:34 a.m., the Director of Maintenance with the surveyor present assessed Resident #6's wheel chair's armrest pad. He stated, "Her arm rest pads most definitely need to be replaced." He said no one ever informed maintenance that Resident's #6's rest needed to be replaced; I will take care of this right away." On 11/13/19 at approximately 11:00 a.m., Resident #6's bilateral armrest pads to her	F 584		

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F 584	Continued From page 3 wheelchair were replaced. A briefing was held with the Administrator and Director of Nursing on 11/14/19 at approximately 4:25 p.m. The facility did not present any further information about the findings. 2. For Resident #27, the wheel chair was observed with worn, torn and cracked armrest pads. Resident #27 was admitted to the facility on 12/08/17. Diagnoses for Resident #27 included but not limited to, muscle weakness. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 09/05/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #27 requiring extensive assistance of one with transfer, dressing, hygiene, bathing, bed mobility and toilet use. The MDS also included extensive assistance of one on and off the unit. The MDS was coded under section G 0600 (mobility devices) was coded for wheel chair usage. During the initial tour of the facility on 11/12/19 at approximately 11:38 a.m., Resident #27 was lying in his bed. His wheel chair was observed with worn, torn and cracked armrest pads. On 11/13/19 at approximately 9:18 a.m., the armrest pads to Resident #27's wheel chair remains unchanged; worn, torn and cracked. On the same day at approximately 11:15 a.m., the Director of Maintenance and surveyor went to Resident #27's room to assess his wheel chair's armrest pads. The Maintenance Director stated,	F 584		

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F 584	Continued From page 4 "Those armrest pads should not look like this, they need to be replaced." He stated, "The plastic is cracked and coming apart." He said the Certified Nursing Assistant (CNA) or nursing should have put a work order in the computer to have the armrests replaced and stated "I will replace them right now." On 11/13/19 at approximately 1:00 p.m., Resident #2's bilateral wheelchair armrests were replaced. A briefing was held with the Administrator and Director of Nursing on 11/14/19 at approximately 4:25 p.m. The facility did not present any further information about the findings.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure one resident	F 600	1. Resident #14 was monitored for any adverse effects from the encounter. No adverse outcomes were observed. 2. All residents with cognitive or communication impairment are at risk from unwanted sexual advances. 3. Staff in all departments will be educated on how to identify different types of abuse to include unwanted sexual advances and the appropriate actions to take. 4. A 100% audit of current employee files will be conducted to ensure staff has completed necessary abuse training. Random audits of staff to include identifying abuse will be conducted 3X a week for two weeks, weekly x two weeks, then monthly x 2 months. Audits will be shared with QAPI committee with revisions to action plan as needed based on audit results.	

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F 600	Continued From page 5 (Resident #14), was free from a sexual encounter initiated by another resident (Resident #44) that occurred on two occasions on 8/30/19. The findings included: Resident #14 was admitted to the facility on 11/14/13 with diagnoses that included but were not limited to dementia with behavioral disturbance and muscle weakness. Resident #14's most recent MDS assessment was a quarterly assessment with an ARD (assessment reference date) of 8/20/19. Resident #14 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded in Section B as sometimes being understood by staff and sometimes understanding staff. Resident #14 was coded as requiring extensive assistance with 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 ARD (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 (Brief 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.	F 600	5. Date of Completion December 27, 2019	

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F 600	Continued From page 6 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 (Resident #44) observed by 2 staff pushing paper into another resident's mouth (Resident #14) while she was sitting in wheelchair at bedside 10:30 p.m. When nurse checked the other resident's mouth-was a ten-dollar bill in her mouth that belonged to resident. When questioned why she put the money in the resident's mouth-would not answer but was laughing. Was placed as nurse's station for close observation as was still awake. Currently sitting quietly in wheelchair at nurse's station." There was no evidence that Resident #44 had any previous history of sexual behaviors prior to 8/30/19. Review of the FRI (facility reported incident) revealed that the facility did not submit a FRI to the appropriate state agencies until 9/4/19. The following was documented: "Incident date 9/1/19; Report date: 9/3/19: Staff reported that resident (Resident #44) was	F 600		

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F 600	Continued From page 7 discovered in resident (Resident #14) room on two occasions and that she appeared to be making sexual advances towards her." The fax confirmation on top of the FRI documented the following: "9-3-19 4:06 p.m." This fax confirmation revealed that the fax had failed to send and the FRI was submitted a second time on "9-4-19 at 8:30 a.m." Review of witness statements collected from staff documented the following: Witness statement collected by CNA (CNA #1) who witnessed incidents: "8/30/19 Friday @ (at) 9:30 p.m., I saw (Name of Resident #44) at the room of (Name of Resident #14) face down in front of (Name of Resident #14) with open brief up to her knee. Called (Name of LPN #3) to help me get her up. At 10:15 p.m. after my rounds I went to the room to check (Name of Resident #14) and I saw (Name of Resident #44) sitting in (Resident #14's) bed trying to open (Name of Resident #14's) brief and money on (Resident #14's) mouth." Witness statement collected by LPN (Licensed Practical Nurse) #3: "8/3019: At approx. (approximately) 2120 (9:20 p.m.) a CNA came up to me and said she needed my help STAT. So we ran down the hall to enter (room of Resident #14) and find (Resident #44) lying on top of residents legs and her brief undone. We assisted her into her chair and helped her into her room. At approximately 2230 (10:30 p.m.). (Resident #44) as found again in (Resident #14's room); again brief undone but this time she was shoving a $10 dollar bill down her throat. I pulled it out and asked what she was doing and she just giggled.	F 600		

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F 600	Continued From page 8 (Resident #44) was brought to nurses station for monitoring. We again asked her what she was doing and she stated, "She called me in there." the (sic) started to giggling again. Will keep at nurses station." An email was attached the witness statements from the LPN #1, the nurse assigned to Resident #44 on 8/30/19 to the Facility Vice President of Operations (not the facility administrator) and the DON (Director of Nursing). The email was written on 8/31/19 at 4:08 a.m. The following was documented: "...I wanted to make you aware of an incident -actually 2 that happened on my shift 8/30, at 9 p.m.- staff found (Name of Resident #44) lying in bed on top of (Name of Resident #14). No apparent injuries and (Name of Resident #44) was taken back to her room. Then at 10:30 pm- staff again found (Resident #44) sitting in her wheelchair besides (Resident #14) bed stuffing a 10 dollar bill into her mouth while laughing. (Name of Resident #14) not harmed and again we took (Resident #14) out of the room and kept her with staff all night-either at the nurses station or in small dining room. I was unsure what to do besides chart incidents, put in doctor's book and I did write a STARS (name of internal incident reporting system) reports. (Name of Resident #44 has (Name of Healthcare organization) as #1 contact- she is more confused now & (and) maybe dangerous to the residents? Let me know if there is anything else to be done..." There was no evidence that the facility Administrator was made aware of the above two incidents until 9/2/19 (when an investigation was initiated).	F 600		

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F 600	Continued From page 9 The five-day follow up to the FRI was completed and faxed to the appropriate state agencies on 9/6/19. The following was documented in part by the facility administrator; "This writer (facility administrator) interviewed (Resident #44) regarding event. (Name of Resident #44) appeared to have difficulty with her recall but stated she remembered being in the room and that she had followed (Name of Resident #14) there. She stated she was trying to help her. When asked whether she was attempting to make sexual advances towards (Name of Resident #14), Resident #44 stated that she was not. Based on the observations of staff and the context of the two events it appears that (Name of Resident #44) was making sexual advances towards (Name of Resident #14). Sexual abuse is not substantiated due to the inability to assign intent to (Resident #44's) actions due to her psychiatric history of delusions. (Name of Resident #44) does not have a history of behaviors but has not demonstrated sexual aggressiveness or inappropriateness since her admission. This new behavior does present a risk and the appropriate follow up action will be taken." Review of Resident #44's clinical record revealed the physician had evaluated Resident #44 on 9/1/19. The following in part, was documented: "I was called over the weekend because the patient had severe inappropriate behavior of a sexual nature where she was grabbing people (staff) by the genitals when they were trying to bathe her. She was going into other patient's room and touching them. She remembers none of this...we ordered some basic labs but the patient refused to have a urinalysis done...There would be no changes in her medications that account for this.	F 600		

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F 600	Continued From page 10 The only behavioral change we can think of is that her sons apparently stopped communicating with her and they blocked her phone from being able to call...We have asked psychiatry to see her I think that is important. I think this is psychiatric not medical. She is not harmful or suicidal." Review of Resident #44's clinical record revealed that psychiatry services evaluated Resident #44 on 9/10/19. The following was documented in part by the psych NP (nurse practitioner): "Patient seen today at staff request. Reason: Resident involved in sexually inappropriate behavior...Residenty (sic) reprots (sic) she does not think the behavior was inappropriate. Nobedoy (sic) actually had sex. Reprots (sic) that she is not going to hurt anyone or do anything to make anyone feel bad. Rewident (sic) reprotsw (sic) she is having (sic) visual and auditory aghllucinations (sic), but denies that the voices had anything to do with incident...Staff reports frequent concerns expressed related to lonliness (sic)...Current Medications: Perphenazine (2) 2 mg tablet Reason: schizophrenia BID (two times a day), Mirtazapine (3) 30 mg tablet Reason: depression QHS (every night)...Assessment/Plan: 1. Schizophrenia with treatment currently not treating to target. Add Risperdol (4) 0.25 mg (milligrams) PO (by mouth) BID (two times a day) for additional treatment. 2. Depression features have increased. Add Zoloft (5) 50 mg po qd (every day). Also used to improve restraint for sexually inappropriate behaviors." Review of Resident #44's September 2019 physician order summary revealed that these medications changes were implemented by staff. Review of Resident #44's behavioral care plan	F 600		

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F 600	Continued From page 11 dated 7/23/19 and revised 9/18/19, revealed the following new interventions: "Educate (Name of Resident #44) on inappropriate behaviors and consequences of exhibiting inappropriate behaviors. Redirect (Name of Resident #44) as needed. Medication as ordered." Review of Resident #14's comprehensive care plan dated 8/21/19 revealed that her care plan was not revised to reflect this incident. There was no evidence of any further incidents with Resident #44. On 11/14/19 at 10:13 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager. When asked the process if she were to find a resident on top of another resident with their brief undone, RN #1 stated that she would immediately separate the residents, do an assessment on both residents "looking for any signs of physical issues". RN #1 stated that she would make the physician aware and interview the residents if able. RN #1 stated that she would also report this incident immediately to the DON (Director of Nursing) and Administrator. RN #1 stated that she would start an investigation soon after the residents were separated because the incident could end up being sexual abuse. RN #1 stated that she would document the incident in a progress notes as well as the head to toe assessment. RN #1 stated that the care plan should also be revised for both residents to alert staff on the incident between the two residents. RN #1 stated that frequent monitoring would also be initiated for both residents. When asked why frequent monitoring would be initiated, RN #1 stated to prevent the resident from doing it again. RN #1 stated that psych maybe be consulted if	F 600		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

needed as well. RN #1 stated that monitoring was usually kept in a paper soft file, not in the clinical record. RN #1 stated that she believed the administrator reported any incidents of alleged abuse to the appropriate state agencies. When asked who was the abuse coordinator, RN #1 stated that it was the facility administrator. When asked if could define sexual abuse, RN #1 stated that sexual abuse was any type of forced sexual encounter that was not consensual. RN #1 stated that she was not involved in the above incident with Resident #44 and Resident #14. RN #1 stated that she was the unit manager for a different unit (unit one) and that the facility currently did not have a unit manager for the unit that both residents reside on (unit two). RN #1 was asked if she could provide any evidence that q 15 minute checks were conducted after these two incidents on 8/30/19.

On 11/14/19 at 11:19 a.m., RN #1 presented q 15 minute checks for Resident #44. Review of Resident #44's visual check audits revealed that Resident #44 was placed on every 15 minute visual checks starting from 9/1/19 until 10/1/19.

There was no evidence that safety checks were initiated after the first incident between Resident #44 and Resident #14 on 8/30/19.

On 11/14/19 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA who witnessed both incidents. When asked what she could recall about that shift 8/30/19, CNA #1 stated that while making her rounds on Resident #14 at approximately 9:15 p.m., she went into Resident #14's room and saw Resident #44 laying across Resident #14's legs, face down in front of Resident #14. CNA #1 first

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F 600	Continued From page 13 stated that Resident #14 still had her gown in place and her brief was intact. When shown CNA #1 her witness statement written on 8/30/19, CNA #1 then stated that she was having a hard time remembering but that if she had written that Resident #14's brief was undone, than it must have been undone. CNA #1 stated that Resident #44 was lying face down on Resident #14; her face in contact with Resident #14's skin because her brief was undone. CNA #1 could not recall exactly where Resident #44's head aligned with Resident #14. CNA #1 then stated at this moment she called for the nurse (LPN #3), and both her and the nurse assisted Resident #44 back into her wheelchair. CNA #1 stated that they brought Resident #44 back into her room. CNA #1 stated she fixed Resident #14's brief. CNA #1 stated that she asked Resident #44 what she was doing but did not get an answer. CNA #1 stated that after that incident she continued to do rounds on her residents and remembered seeing Resident #44 at the nurses station but could not remember the time. CNA #1 stated that at approximately 10:45 p.m., she checked on Resident #14 and saw Resident #44 again in Resident #14's room. CNA #1 stated that Resident #14's gown and brief were open and that Resident #44 had her hand in Resident #14's private area. CNA #1 stated that she had also saw money in Resident #14's mouth. CNA #1 stated that Resident #44 was asked what she was doing and that Resident #44 had just giggled. CNA #1 stated that Resident #14 was also smiling. When asked if she felt that Resident #14 was capable of consenting to inappropriate touching, CNA #1 stated she didn't think so. When asked who was responsible for ensuring Resident #14 was safe from Resident #44, CNA #1 stated that it was a team effort, that everyone was responsible for ensuring Resident	F 600		

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F 600	Continued From page 14 #44 did not re-enter Resident #44's room. CNA #1 stated that she tried to watch Resident #44 after the first encounter but that she had to rounds on her residents. CNA #1 stated that she did not recall signing any "q (every) 15 minute check" sheet" after the first incident. CNA #1 could not recall much after the second incident because she gave report and went home shortly after. CNA #1 stated that she did write a statement of the two incidents that same day. On 11/14/19 at 12:30 p.m., an interview was conducted with LPN #3, the nurse who witnessed both incidents on 8/30/19. When asked what she could recall that shift, LPN #3 stated that the CNA came and grabbed her and looked frantic. LPN #3 stated that she was told that Resident #44 had fallen on top of Resident #14. LPN #3 stated that she thought Resident #44 had gotten up from her wheelchair, lost balance and fallen on Resident #14. When asked how Resident #14 presented when she saw Resident #44 on top of her, LPN #3 stated that she couldn't recall what Resident #14 looked like, but that she didn't look disheveled or in distress. LPN #3 stated that she could not remember if Resident #14's brief was undone but if, she wrote that her brief was undone in her witness statement, then her brief was probably undone. When asked if Resident #14 had the capacity to open her open brief, LPN #3 stated that Resident #14 had never done that before, but if she is combative, she had a tendency to become disheveled. LPN #3 stated that she did a head to toe assessment on both residents for any injury because she had thought Resident #44 had fallen on Resident #14. When asked if Resident #14 was able to consent to any sexual activity, LPN #3 stated, "Our brains didn't go there." LPN #3 stated that after the first	F 600		

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F 600	Continued From page 15 incident, she and the CNA brought Resident #44 back to her room. LPN #3 then stated shortly after the CNA grabbed her again and when she went into the Resident #14's room, she saw Resident #44 actively putting money in Resident #14's mouth and Resident #14's brief was undone. LPN #3 stated that they did not start rounding on Resident #44 until after the second incident. LPN #3 stated that they did not think the first incident was sexual in nature but then thought the second incident was a "weird situation." LPN #3 stated that looking back now, the first incident could have been a sexual encounter. LPN #3 stated that she had conducted an assessment after the second incident on both residents and there were no obvious injuries. LPN #3 stated that Resident #44 was kept at the nurse's station after the second encounter. When asked if she documented safety checks anywhere, LPN #3 stated that she just documented what she had done during her shift, that she did not initiate a paper q (every) 15 minute check audit. When asked if she had reported the two incidents, LPN #3 stated that she was not the assigned nurse for Resident #14 or Resident #44 and that she had let the assigned nurse know. LPN # 3 also stated that she wrote a witness statement that shift. LPN #3 confirmed that she did not report these incidents to the administrator or DON (Director of Nursing). When asked who the abuse coordinator was, LPN #3 stated that DON or clinical manager was the abuse coordinator. When asked when to report an allegation of any type of abuse, LPN #3 stated that allegations of abuse should be reported immediately, "even in the middle of the night." LPN #3 confirmed that her witness statement was left at the facility for the DON when she returned to work the following Monday.	F 600		

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F 600	Continued From page 16 On 11/14/19 at approximately 3:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked when she was made aware of the two incidents between Resident #14 and Resident #44, ASM #1 stated that she became aware on 9/2/19 when the interim VP (Vice President) of Operations had notified her. ASM #1 stated that the nurse on shift (LPN #1) had filled out a STARS report (incident reporting system) on 8/30/19 that alerted the VP of Operations about the incidents. When asked if the VP of Operations is checking the STARS reports after hours on the weekend, ASM #1 stated that she was not sure. ASM #1 also stated that she was not sure if staff were checking email after hours. When asked if she expected her staff to report these two incidents sooner, ASM #1 stated that in this particular situation, the staff did not feel that the first incident was abuse, they just felt that the situation was "weird". ASM #1 stated that the staff went through the normal incident reporting process. ASM #1 stated that Resident #44 also had no previous history of sexual behaviors. When asked about reporting the second incident, ASM #1 stated that the second incident "probably should have been reported to me" but then stated it was reported to her through the incident management system. ASM #1 stated that maybe reporting through the incident management system was "not the most efficient." When asked when staff should report any allegations of abuse, ASM #1 stated that allegations of abuse should be reported immediately to her (the abuse coordinator). ASM #1 stated that abuse should be reported within two hours to the appropriate state agencies if abuse had caused bodily harm or within 24 hours. When asked why Resident #44 was placed on	F 600		

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F 600	Continued From page 17 safety checks starting 9/1/19, ASM #1 stated to prevent any further episodes of sexual behavior with other residents. On 11/14/19 at 9:59 a.m., and 3:07 p.m., interviews were attempted with LPN #1, the assigned nurse that shift on 8/30/19. She could not be reached for an interview. A message was left asking for a return call. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. The facility's abuse policy documents in part, the following: "... Sexual abuse: is non consensual sexual contact of any type with a resident. Identification: It is the policy that all staff monitor residents/participants and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse will be investigated...Protection: Abuse policy requirements. It is the policy the resident/participant will be protected from the alleged offender... The alleged perpetrator will be immediately removed and the resident/participant protected. If the alleged perpetrator is a resident/participant, the staff members will immediately remove the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from the administrator, if possible. Examine, assess, and interview the resident/participant and other residents/participants potentially affected immediately to determine any injury and identify immediate clinical interventions necessary."	F 600		

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F 600	Continued From page 18 (1) Lewy body dementia "(LBD) is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. Lewy body dementia is one of the most common causes of dementia." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/what-lewy-body-dementia#what. (2) Perphenazine is an antipsychotic used to treat schizophrenia. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK548366/. (3) Mirtazapine is an antidepressant used to treat major depressive disorder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK548216/. (4) Risperdol (Risperidone) is an atypical antipsychotic that is used widely in the treatment of mania and schizophrenia. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK548906/ (5) Zoloft (Sertraline) is a selective serotonin reuptake inhibitor (SSRI) used in the therapy of depression, anxiety disorders and obsessive-compulsive disorder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK548513/.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607	1. Resident #14 was monitored for any adverse effects from the encounter. No adverse outcomes were observed.	

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F 607	Continued From page 19 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to implement abuse policies for 2 of 38 residents in the survey sample to ensure Resident #14 was free from a second sexual encounter by Resident #44 that occurred on 8/30/19; and failed to report an allegation of abuse to the facility administrator and to the appropriate state agencies in a timely manner. The findings included: Resident #14 was admitted to the facility on 11/14/13 with diagnoses that included but were not limited to dementia with behavioral disturbance and muscle weakness. Resident #14's most recent MDS assessment was a quarterly assessment with an ARD (assessment reference date) of 8/20/19. Resident #14 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded in Section B as sometimes being understood by staff and sometimes understanding staff. Resident #14 was coded as requiring extensive assistance with	F 607	2. All residents are at risk when abuse policies are not implemented and potential abuse situations are not reported in a timely manner. 3. Staff in all departments will be educated on the facility abuse policy to include how to identify abuse, appropriate action to take to ensure resident safety, and the process for escalating unusual occurrences or potential abuse situations to Administrative staff. 4. A 100% audit of current employee files to ensure staff has completed training on facility abuse policy. Random audits of staff to include identifying abuse, intervention for resident safety, and escalation process will be conducted 3X a week for two weeks, weekly x two weeks, then monthly x 2 months. Audits will be shared with QAPI committee with revisions to action plan as needed based on audit results. 5. Date of Completion December 27, 2019	

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F 607	Continued From page 20 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 ARD (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 (Brief 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 (Resident #44) observed by 2 staff pushing paper into another resident's mouth (Resident #14) while she was sitting in wheelchair at bedside 10:30 p.m. When nurse checked the other resident's	F 607		

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F 607	Continued From page 21 mouth-was a ten-dollar bill in her mouth that belonged to resident. When questioned why she put the money in the resident's mouth-would not answer but was laughing. Was placed as nurse's station for close observation as was still awake. Currently sitting quietly in wheelchair at nurses' station." There was no evidence that Resident #44 had any previous history of sexual behaviors prior to 8/30/19. Review of the FRI (facility reported incident) revealed that the facility did not submit a FRI to the appropriate state agencies until 9/4/19. The following was documented: "Incident date 9/1/19; Report date: 9/3/19: Staff reported that resident (Resident #44) was discovered in resident (Resident #14) room on two occasions and that she appeared to be making sexual advances towards her." The fax confirmation on top of the FRI documented the following: "9-3-19 4:06 p.m." This fax confirmation revealed that the fax had failed to send and the FRI was submitted a second time on "9-4-19 at 8:30 a.m." Review of witness statements collected from staff documented the following: Witness statement collected by CNA (CNA #1) who witnessed incidents: "8/30/19 Friday @ (at) 9:30 p.m., I saw (Name of Resident #44) at the room of (Name of Resident #14) face down in front of (Name of Resident #14) with open brief up to her knee. Called (Name of nurse) to help me get her up. At 10:15 p.m. after my rounds I went to the room to check (Name of Resident	F 607		

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F 607	Continued From page 22 #14) and I saw (Name of Resident #44) sitting in (Resident #14's) bed trying to open (Name of Resident #14's) brief and money on (Resident #14's) mouth." Witness statement collected by LPN (Licensed Practical Nurse) #3: "8/3019: At approx. (approximately) 2120 (9:20 p.m.) a CNA came up to me and said she needed my help STAT. So we ran down the hall to enter (room of Resident #14) and find (Resident #44) lying on top of residents legs and her brief undone. We assisted her into her chair and helped her into her room. At approximately 2230 (10:30 p.m.). (Resident #44) as found again in (Resident #14's room); again brief undone but this time she was shoving a $10 dollar bill down her throat. I pulled it out and asked what she was doing and she just giggled. (Resident #44) was brought to nurses station for monitoring. We again asked her what she was doing and she stated, "She called me in there." the (sic) started to giggling again. Will keep at nurses station." An email was attached the witness statements from the nurse (LPN #1) assigned to Resident #44 on 8/30/19 to the Facility Vice President of Operations (not the administrator) and the DON (Director of Nursing). The was written on 8/31/19 at 4:08 a.m. The following was documented: "...I wanted to make you aware of an incident -actually 2 that happened on my shift 8/30, at 9 p.m.- staff found (Name of Resident #44) lying in bed on top of (Name of Resident #14). No apparent injuries and (Name of Resident #44) was taken back to her room. Then at 10:30 pm- staff again found (Resident #44) sitting in her wheelchair besides (Resident #14) bed stuffing a 10 dollar bill into her mouth while laughing.	F 607		

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F 607	Continued From page 23 (Name of Resident #14) not harmed and again we took (Resident #14) out of the room and kept her with staff all night - either at the nurses station or in small dining room. I was unsure what to do besides chart incidents, put in doctor's book and I did write a STARS (name of internal incident reporting system) reports. (Name of Resident #44 has (Name of Healthcare organization) as #1 contact- she is more confused now & (and) maybe dangerous to the residents? Let me know if there is anything else to be done..." There was no evidence that the facility administrator was made aware of the above two incidents until 9/2/19 (when an investigation was initiated). The five-day follow up FRI was completed and faxed to the appropriate state agencies on 9/6/19. The following was documented in part; "This writer (facility administrator) interviewed (Resident #44) regarding event. (Name of Resident #44) appeared to have difficulty with her recall but stated she remembered being in the room and that she had followed (Name of Resident #14) there. She stated she was trying to help her. When asked whether she was attempting to make sexual advances towards (Name of Resident #14), Resident #44 stated that she was not. Based on the observations of staff and the context of the two events it appears that (Name of Resident #44) was making sexual advances towards (Name of Resident #14). Sexual abuse is not substantiated due to the inability to assign intent to (Resident #44's) actions due to her psychiatric history of delusions. (Name of Resident #44) does not have a history of behaviors but has not demonstrated sexual aggressiveness or inappropriateness since her admission. This new behavior does present a risk and the appropriate follow up action will be	F 607		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING AND REHAB CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24 taken." On 11/14/19 at 10:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked the process if she were to find a resident on top of another resident with his or her brief undone, RN #1 stated that she would immediately separate the residents, do an assessment on both residents "looking for any signs of physical issues". RN #1 stated that she would make the physician aware and interview the residents if able. RN #1 stated that she would also report this incident immediately to the DON (Director of Nursing) and Administrator. RN #1 stated that she would start an investigation soon after the residents were separated because the incident could end up being sexual abuse. RN #1 stated that frequent monitoring would also be initiated for both residents. When asked why frequent monitoring would be initiated, RN #1 stated to prevent the resident from doing it again. RN #1 stated that she believed the administrator reported any incidents of alleged abuse to the appropriate state agencies. When asked who was the abuse coordinator, RN #1 stated that it was the facility administrator. When asked if could define sexual abuse, RN #1 stated that sexual abuse was any type of forced sexual encounter that was not consensual. There was no evidence that safety checks were initiated after the first incident between Resident #44 and Resident #14 on 8/30/19. Every 15 minute checks were not initiated until 9/1/19. On 11/14/19 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA who witnessed both incidents. When asked who was responsible for ensuring Resident	F 607		

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F 607	Continued From page 25 #14 was safe from Resident #44, CNA #1 stated that it was a team effort, that everyone was responsible for ensuring Resident #44 did not re-enter Resident #44's room. CNA #1 stated that she tried to watch Resident #44 after the first encounter but that she had to round on her residents. CNA #1 stated that she did write a statement of the two incidents that same day that was left for the Director of Nursing. On 11/14/19 at 12:30 p.m., an interview was conducted with LPN #3, the nurse who witnessed both incidents on 8/30/19. When asked if Resident #14 was able to consent to any sexual activity, LPN #3 stated, "Our brains didn't go there." LPN #3 stated that after the first incident, her and the CNA brought Resident #44 back to her room. LPN #3 then stated shortly after the CNA grabbed her again and when she went into the Resident #14's room, she saw Resident #44 actively putting money in Resident #14's mouth and Resident #14's brief was undone. LPN #3 stated that they did not start rounding on Resident #44 until after the second incident. LPN #3 stated that they did not think the first incident was sexual in nature but then thought the second incident was a "weird situation." LPN #3 stated that looking back now, the first incident could have been a sexual encounter. LPN #3 stated that Resident #44 was kept at the nurse's station after the second encounter. When asked if she documented safety checks anywhere, LPN #3 stated that she just documented what she had done during her shift, that she did not initiate a paper q (every) 15 minute check audit. When asked if she had reported the two incidents, LPN #3 stated that she was not the assigned nurse for Resident #14 or Resident #44 and that she had let the assigned nurse know. LPN # 3 also stated	F 607		

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F 607	Continued From page 26 that she wrote a witness statement that shift. LPN #3 confirmed that she did not report these incidents to the administrator or DON (Director of Nursing). When asked who was the abuse coordinator, LPN #3 stated that DON or clinical manager was the abuse coordinator. When asked when to report an allegation of any type of abuse, LPN #3 stated that allegations of abuse should be reported immediately, "even in the middle of the night." LPN #3 confirmed that her witness statement was left at the facility for the DON when she returned to work the following Monday. On 11/14/19 at approximately 3:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the Administrator. When asked when she was made aware of the two incidents between Resident #14 and Resident #44, ASM #1 stated that she became aware on 9/2/19 when the interim VP (Vice President) of Operations had notified her. ASM #1 stated that the nurse on shift (LPN #1) had filled out a STARS report (incident reporting system) on 8/30/19 that alerted the VP of Operations about the incidents. When asked if the VP of Operations checks the STARS reports after hours on the weekend, ASM #1 stated that she was not sure. ASM #1 also stated that she was not sure if staff were checking email after hours. When asked if she expected her staff to report these two incidents sooner, ASM #1 stated that in this particular situation, the staff did not feel that the first incident was abuse, they just felt that the situation was "weird". ASM #1 stated that the staff went through the normal incident reporting process. ASM #1 stated that Resident #44 also had no previous history of sexual behaviors. When asked about reporting the second incident, ASM #1 stated that the second	F 607		

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F 607	Continued From page 27 incident "probably should have been reported to me" but then stated it was reported to her through the incident management system. ASM #1 stated that maybe reporting through the incident management system was "not the most efficient." When asked when staff should report any allegation of abuse, ASM #1 stated that allegations of abuse should be reported immediately to her (the abuse coordinator). ASM #1 stated that abuse should be reported within two hours to the appropriate state agencies if abuse had caused bodily harm or within 24 hours. When asked why Resident #44 was placed on safety checks starting 9/1/19, ASM #1 stated to prevent any further episodes of sexual behavior with other residents. On 11/14/19 at 9:59 a.m., and 3:07 p.m., interviews were attempted with LPN #1, the assigned nurse that shift on 8/30/19. She could not be reached for an interview. A message was left asking for a return call. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. The facility's abuse policy documents in part, the following: "... Sexual abuse: is non consensual sexual contact of any type with a resident. Identification: It is the policy that all staff monitor residents/participants and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse will be investigated...Protection: Abuse policy requirements. It is the policy the resident/participant will be protected from the	F 607		

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F 607	Continued From page 28 alleged offender... The alleged perpetrator will be immediately removed and the resident/participant protected. If the alleged perpetrator is a resident/participant, the staff members will immediately remove the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from the administrator, if possible. Examine, assess, and interview the resident/participant and other residents/participants potentially affected immediately to determine any injury and identify immediate clinical interventions necessary...The facility will ensure that all alleged violations of involving abuse, neglect, exploitation or mistreatment...are reported to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with State law through established procedures. Reporting must occur immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse or do not result in serious bodily injury." (1) Lewy body dementia "(LBD) is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. Lewy body dementia is one of the most common causes of dementia." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/what-lewy-body-de	F 607		

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F 607	Continued From page 29 mentia#what.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to report an allegation of abuse that occurred between two residents of 38	F 609	1. No corrective action could be taken as the reporting time frame had passed. 2. All residents are at risk when potential abuse is not reported in a timely manner 3. Staff in all departments will be educated on abuse reporting timelines and procedures for escalating potential abuse scenarios and unusual occurrences. 4. A 100% audit of current employee files to ensure staff has completed training on facility abuse reporting timelines. Random audits of staff in all departments on escalation process for suspected abuse or unusual occurrences will be conducted 3X a week for two weeks, weekly x two weeks, then monthly x 2 months. Audits will be shared with QAPI committee with revisions to action plan as needed based on audit results. 5. Date of Completion December 27, 2019	

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F 609	Continued From page 30 sampled residents (Resident #44 and Resident #14) to the facility Administrator and to the appropriate State Agencies in a timely manner. The findings included: 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 ARD (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 (Brief 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. Resident #14 was admitted to the facility on 11/14/13 with diagnoses that included but were not limited to dementia with behavioral disturbance and muscle weakness. Resident #14's most recent MDS assessment was a quarterly assessment with an ARD (assessment reference date) of 8/20/19. Resident #14 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded in Section B as sometimes being understood by staff and sometimes understanding staff. Resident #14 was coded as requiring extensive assistance with one staff member with bed mobility, and dressing; and total dependence on staff with personal hygiene.	F 609		

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F 609	Continued From page 31 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 (Resident #44) observed by 2 staff pushing paper into another resident's mouth (Resident #14) while she was sitting in wheelchair at bedside 10:30 p.m. When nurse checked the other resident's mouth-was a ten-dollar bill in her mouth that belonged to resident. When questioned why she put the money in the resident's mouth-would not answer but was laughing. Was placed as nurse's station for close observation as was still awake. Currently sitting quietly in wheelchair at nurses's station." Review of the FRI (facility reported incident) revealed that the facility did not submit a FRI to the appropriate state agencies until 9/4/19. The following was documented: "Incident date 9/1/19; Report date: 9/3/19: Staff reported that resident (Resident #44) was discovered in resident (Resident #14) room on two occasions and that she appeared to be making sexual advances towards her."	F 609		

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F 609	Continued From page 32 The fax confirmation on top of the FRI documented the following: "9-3-19 4:06 p.m." This fax confirmation revealed that the fax had failed to send and the FRI was submitted a second time on "9-4-19 at 8:30 a.m." Review of witness statements collected from staff documented the following: Witness statement collected by CNA (CNA #1) who witnessed incidents: "8/30/19 Friday @ (at) 9:30 p.m., I saw (Name of Resident #44) at the room of (Name of Resident #14) face down in front of (Name of Resident #14) with open brief up to her knee. Called (Name of nurse) to help me get her up. At 10:15 p.m. after my rounds I went to the room to check (Name of Resident #14) and I saw (Name of Resident #44) sitting in (Resident #14's) bed trying to open (Name of Resident #14's) brief and money on (Resident #14's) mouth." Witness statement collected by Licensed Practical Nurse (LPN) #3: "8/3019: At approx. (approximately) 2120 (9:20 p.m.) a CNA came up to me and said she needed my help STAT. So we ran down the hall to enter (room of Resident #14) and find (Resident #44) lying on top of residents legs and her brief undone. We assisted her into her chair and helped her into her room. At approximately 2230 (10:30 p.m.). (Resident #44) as found again in (Resident #14's room); again brief undone but this time she was shoving a $10 dollar bill down her throat. I pulled it out and asked what she was doing and she just giggled. (Resident #44) was brought to nurses station for monitoring. We again asked her what she was doing and she stated, "She called me in there." the (sic) started to giggling again. Will keep at	F 609		

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F 609	Continued From page 33 nurses station." An email was attached the witness statements from the nurse (LPN #1) assigned to Resident #44 on 8/30/19 to the Facility Vice President of Operations (not the facility administrator) and the DON (Director of Nursing). The email was written on 8/31/19 at 4:08 a.m. The following was documented: "...I wanted to make you aware of an incident -actually 2 that happened on my shift 8/30, at 9 p.m.- staff found (Name of Resident #44) lying in bed on top of (Name of Resident #14). No apparent injuries and (Name of Resident #44) was taken back to her room. Then at 10:30 pm- staff again found (Resident #44) sitting in her wheelchair besides (Resident #14) bed stuffing a 10 dollar bill into her mouth while laughing. (Name of Resident #14) not harmed and again we took (Resident #14) out of the room and kept her with staff all night - either at the nurses station or in small dining room. I was unsure what to do besides chart incidents, put in doctors book and I did write a STARS (name of internal incident reporting system) reports. (Name of Resident #44 has (Name of Healthcare organization) as #1 contact- she is more confused now & (and) maybe dangerous to the residents? Let me know if there is anything else to be done..." There was no evidence that the facility administrator was made aware of the above two incidents until 9/2/19 (when an investigation was initiated). The five-day follow up FRI was completed and faxed to the appropriate state agencies on 9/6/19. The following was documented in part; "This writer (facility administrator) interviewed (Resident #44) regarding event. (Name of Resident #44) appeared to have difficulty with her recall but	F 609		

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F 609	Continued From page 34 stated she remembered being in the room and that she had followed (Name of Resident #14) there. She stated she was trying to help her. When asked whether she was attempting to make sexual advances towards (Name of Resident #14), Resident #44 stated that she was not. Based on the observations of staff and the context of the two events it appears that (Name of Resident #44) was making sexual advances towards (Name of Resident #14). Sexual abuse is not substantiated due to the inability to assign intent to (Resident #44's) actions due to her psychiatric history of delusions. (Name of Resident #44) does not have a history of behaviors but has not demonstrated sexual aggressiveness or inappropriateness since her admission. This new behavior does present a risk and the appropriate follow up action will be taken." On 11/14/19 at 10:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked the process if she were to find a resident on top of another resident with his or her brief undone, RN #1 stated that she would immediately separate the residents, do an assessment on both residents "looking for any signs of physical issues". RN #1 stated that she would make the physician aware and interview the residents if able. RN #1 stated that she would also report this incident immediately to the DON (Director of Nursing) and Administrator. RN #1 stated that she believed the administrator reported any incidents of alleged abuse to the appropriate state agencies. When asked who was the abuse coordinator, RN #1 stated that it was the facility administrator. When asked if could define sexual abuse, RN #1 stated that sexual abuse was any type of forced sexual	F 609		

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F 609	Continued From page 35 encounter that was not consensual. On 11/14/19 at 12:30 p.m., an interview was conducted with LPN #3, the nurse who witnessed both incidents on 8/30/19. When asked if Resident #14 was able to consent to any sexual activity, LPN #3 stated, "Our brains didn't go there." LPN #3 stated that after the first incident, her and the CNA brought Resident #44 back to her room. LPN #3 then stated shortly after the CNA grabbed her again and when she went into the Resident #14's room, she saw Resident #44 actively putting money in Resident #14's mouth and Resident #14's brief was undone. LPN #3 stated that they did not start rounding on Resident #44 until after the second incident. LPN #3 stated that they did not think the first incident was sexual in nature but then thought the second incident was a "weird situation." LPN #3 stated that looking back now, the first incident could have been a sexual encounter. When asked if she had reported the two incidents, LPN #3 stated that she was not the assigned nurse for Resident #14 or Resident #44 and that she had let the assigned nurse know. LPN # 3 also stated that she wrote a witness statement that shift. LPN #3 confirmed that she did not report these incidents to the administrator or DON (Director of Nursing). When asked who was the abuse coordinator, LPN #3 stated that DON or clinical manager was the abuse coordinator. When asked when to report an allegation of any type of abuse, LPN #3 stated that allegations of abuse should be reported immediately, "even in the middle of the night." LPN #3 confirmed that her witness statement was left at the facility for the DON when she returned to work the following Monday. On 11/14/19 at approximately 3:00 p.m., an	F 609		

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F 609	Continued From page 36 interview was conducted with ASM (administrative staff member) #1, the Administrator. When asked when she was made aware of the two incidents between Resident #14 and Resident #44, ASM #1 stated that she became aware on 9/2/19 when the interim VP (Vice President) of Operations had notified her. ASM #1 stated that the nurse on shift (LPN #1) had filled out a STARS report (incident reporting system) on 8/30/19 that alerted the VP of Operations about the incidents. When asked if the VP of Operations is checking the Stars report after hours on the weekend, ASM #1 stated that she was not sure. ASM #1 also stated that she was not sure if staff were checking email after hours. When asked if she expected her staff to report these two incidents sooner, ASM #1 stated that in this particular situation, the staff did not feel that the first incident was abuse, they just felt that the situation was "weird". ASM #1 stated that the staff went through the normal incident reporting process. ASM #1 stated that Resident #44 also had no previous history of sexual behaviors. When asked about reporting the second incident, ASM #1 stated that the second incident "probably should have been reported to me" but then stated it was reported to her through the incident management system. ASM #1 stated that maybe reporting through the incident management system was "not the most efficient." When asked when staff should report any allegations of abuse, ASM #1 stated that allegations of abuse should be reported immediately to her (the abuse coordinator). ASM #1 stated that abuse should be reported within two hours to the appropriate state agencies if abuse had caused bodily harm or within 24 hours. On 11/14/19 at 9:59 a.m., and 3:07 p.m., interviews were attempted with LPN #1, the	F 609		

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	495392	A. BUILDING _____ B. WING _____	11/14/2019

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F 609	Continued From page 37 assigned nurse that shift on 8/30/19. She could not be reached for an interview. A message was left asking for a return call. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. The facility's abuse policy documents in part, the following: "...The facility will ensure that all alleged violations of involving abuse, neglect, exploitation or mistreatment...are reported to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with State law through established procedures. Reporting must occur immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse or do not result in serious bodily injury." (1) Lewy body dementia "(LBD) is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. Lewy body dementia is one of the most common causes of dementia." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/what-lewy-body-dementia#what.	F 609		

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F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622	1. Resident #4, #45, #12, #67 and #55 were readmitted to the facility without incident. Resident #70 was accepted for readmission to the facility but did not return. 2. All resident who are discharged from the facility are at risk when the comprehensive care plan is not provided to the receiving facility. 3. Nursing staff will be educated on the process for sending the comprehensive care plan to the receiving facility at the time of discharge. 4. Clinical Managers or designee will conduct ongoing audits of 100% of discharged resident's charts to ensure care plan summaries are sent at the time of discharge. Results of audits will be shared with the QAPI committee. 5. Date of Completion December 27, 2019	

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F 622	Continued From page 39 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

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F 622	Continued From page 40 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to send a copy of the comprehensive care plan to include the residents goals after being transferred to the hospital for 6 of 38 residents in the survey sample (Residents #55, #70, #67, #4, #45, & #12). The findings included: 1. Resident #55 was originally admitted to the facility on 10/30/17 and readmitted on 10/10/19. The current diagnoses included: Hypercalcemia and Alzheimer's disease. The quarterly Minimum Data Set (MDS) an admissions assessment with an assessment reference date (ARD) of 10/17/19, coded the resident with a 6 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating Cognitive skills for decision making shows resident as being severely impaired for daily decision making. On 11/04/19, according to the facility's documentation, Resident #55 departed the facility with transport to the local hospital. On 11/14/19 at approximately, 12:16 PM an interview was conducted with Licensed Practical	F 622		

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F 622	Continued From page 41 Nurse (LPN) #6. She was asked what documents are sent when a resident is being admitted to the hospital. LPN #6 stated, "I usually send the face sheet, medication list, the bed hold policy, DNR paper work and the vital signs. When asked if she would normally include the care plan summary with her documents, she stated, "No." The above findings were shared with the Administrator and Director of Nursing on 11/14/19 at approximately 4:30 PM. No further comments were made. 2. Resident #70 was originally admitted to the facility on 10/06/19 and discharged on 10/18/19. The current diagnoses included: Repeated Falls and Spondylolisthesis. The quarterly Minimum Data Set (MDS) an admissions assessment with an assessment reference date (ARD) of 10/13/19, coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating Cognitive skills for decision making is intact. The Discharge MDS assessment dated 10/18/19 - discharge return not anticipated. On 10/18/19, according to the facility's documentation, Resident #70 departed facility with transport to the local hospital. On 11/14/19 at approximately, 12:16 PM an interview was conducted with Licensed Practical Nurse (LPN) #6. She was asked what documents are sent when a resident is being admitted to the hospital. LPN#6 stated, "I usually send the face sheet, medication list, the bed hold policy, DNR	F 622		

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F 622	Continued From page 42 paper work and the vital signs. When she was asked if she would normally include the care plan summary with her documents, LPN #6 stated "No." The above findings were shared with the Administrator and Director of Nursing on 11/14/19 at approximately 4:30 PM. No further comments were made. 3. Resident #67's latest admission was 8/1/2019 with a transfer to the hospital occurring on 10/15/2019. The latest diagnosis included, but not limited to, acute posthemorrhagic, gram-negative sepsis, adult failure to thrive, and cardiomyopathy. Resident #67's most recent MDS (Minimum Data Set) assessment was a 14 day Scheduled Assessment with an ARD (assessment reference date) of 8/14/2019. Resident #67 was coded as moderate cognitive impairment scoring 14 out of possible 15 on the BIMS (brief interview for mental status) exam. A review of Resident #67's clinical record revealed she was transferred to the hospital on 10/15/2019 due to bloody BM and black tarry stools, observed during change. Clinical record reviews conducted yielded no evidence that care plan goals were submitted to the hospital upon transfer. An interview conducted with the Unit Secretary (Other Staff Member #4) on 11/14/2019 at approximately 3:35 p.m. inquiring about the status of the transfer of care plan goals for Resident #67. Other Staff Member #4 stated "We did not send the care plan goals when she went out. We were not aware that we needed to do that"	F 622		

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F 622	Continued From page 43 The Facility Administrator was informed of the findings during a briefing on 11/14/2019 at approximately 4:15 p.m. The Facility did not present any further information about the findings. 4. Resident #4 was initially admitted to the facility on 10/28/2015. Resident #4's most recent discharge to the hospital was on 10/02/2019 and readmitted to the facility on 10/26/2019. Diagnosis included but were not limited to, End Stage Renal Disease, Dependence on Renal Dialysis and Type 2 Diabetes Mellitus. Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/04/2019 coded Resident #4 with a BIMS (Brief Interview for Mental Status) of 13 indicating no cognitive impairment. In addition the Minimum Data Set coded Resident #4 as requiring extensive assistance of 1 for bed mobility, dressing and personal hygiene and total dependence of 1 with toilet use and bathing. On 11/13/2019 at approximately 9:00 a.m., the surveyor requested evidence that the comprehensive care plan goals were sent with the resident upon discharge to the hospital on 10/02/2019. On 11/13/2019 at approximately 12:00 p.m., the Administrator stated, "The resident was transferred to the hospital from the dialysis center." The Surveyor asked, "Were the care plan goals faxed or provided to the hospital?" The Administrator stated, "I will check." On 11/14/2019 at approximately 1:00 p.m., the Administrator stated, "The care plan goals were not provided to the hospital. The nursing staff on	F 622		

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F 622	Continued From page 44 Unit 2 have more experience than the nurses on Unit 1 with sending the care plan goals to the hospital when residents are discharged. The nurses should have sent the care plan goals 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. 5. 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 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. Review of Resident #45's clinical record revealed that he was transferred to the hospital on 11/6/19. The following nursing note was documented: "Resident is LOA (leave of absence) due to having ab (abdominal pains) the whole day, and at the 6 pm the pains were 30 mins (minutes) apart..." There was no evidence in the clinical record that Resident #45's care plan or care plan goals were sent with the resident upon transfer to the hospital. Resident #45 returned to the facility on	F 622		

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F 622	Continued From page 45 11/9/19. 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 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. 6. Resident #12 was admitted to the facility on 8/14/19 and readmitted on 11/11/19 with diagnoses that included but were not limited to, heart failure, dementia and diabetes. Resident #12's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/14/19. Resident #12 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's clinical record revealed that he had been sent to the hospital on 11/7/19. The following nursing note was documented in part: "...1400 (2:00 p.m.) Resident presented with confusion...Resident refused order for straight	F 622		

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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 (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 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.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625	1. Residents #4, #45, #12, and #55 were all readmitted to the facility prior to the survey without incident	

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F 625	Continued From page 47 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide 4 of 38 residents in the survey sample, and/or the resident representative, a written bed hold notice when discharged to the hospital (Residents #4, #45, #12, #55). The findings included: The facility policy titled-Life Care-Bed Hold	F 625	2. All residents discharged from the facility are at risk when bed hold information is not provided. 3. Nursing staff will be educated on the process for providing bed hold information to the resident at the time of discharge. 4. Clinical Managers or designee will conduct ongoing audits of 100% of discharged resident's charts to ensure care plan summaries are sent at the time of discharge. Results of audits will be shared with the QAPI committee. 5. Date of Completion December 27, 2019	

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F 625	Continued From page 48 included: Policy Statement: It is the facility policy to inform the resident or resident representative of the durations of the bed-hold policy, if any, during which the resident is permitted to return and resume residence when admitted to an acute care facility or goes on therapeutic leave. ...Resident or Resident Representative will be provided a 'Notice of Bed Hold Policy' letter at time of transfer; if not immediately possible, notification will be at first available opportunity. ...Notice of bed hold policy will be provided with transfer documents. 1. Resident #4 was initially admitted to the facility on 10/28/2015. Resident #4's most recent discharge to the hospital was on 10/02/2019 and readmitted to the facility on 10/26/2019. Diagnoses included but were not limited to, End Stage Renal Disease, Dependence on Renal Dialysis and Type 2 Diabetes Mellitus. Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/04/2019 coded Resident #4 with a BIMS (Brief Interview for Mental Status) of 13 indicating no cognitive impairment. In addition the Minimum Data Set coded Resident #4 as requiring extensive assistance of 1 for bed mobility, dressing and personal hygiene and total dependence of 1 with toilet use and bathing. On 11/13/2019 at approximately 12:00 p.m., after a request for evidence that the bed hold policy was provided to the resident, the Administrator stated, "The resident was transferred to the hospital from the dialysis center."	F 625		

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SENTARA NURSING AND REHAB CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

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F 625	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 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.	F 625		

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F 625	Continued From page 50 There was no evidence in the clinical record that written bed hold notification was sent with Resident #45 upon transfer to the hospital on 11/6/19. Resident #45 returned to the facility on 11/9/19. 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 was asked to find evidence that a bed hold notice was sent with Resident #45 upon transfer to the hospital. This information could not be provided. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information could be presented prior to exit. 3. Resident #12 was admitted to the facility on 8/14/19 and readmitted on 11/11/19 with diagnoses that included but were not limited to heart failure, dementia and diabetes. Resident #12's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/14/19. Resident #12 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 625		

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F 625	Continued From page 51 Review of Resident #12's clinical record revealed that he had been sent to the hospital on 11/7/19. The following nursing note was documented in part: "...1400 (2:00 p.m.) Resident presented with confusion...911 called. Transported to (name of hospital) at 1530 (3:30 p.m.) via ambulance...." There was no evidence in the clinical record that written bed hold notification was sent with Resident #12 upon transfer to the hospital on 11/7/19. Resident #12 returned to the facility on 11/11/19. 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 was asked to find evidence that a bed hold notice was sent with Resident #12 upon transfer to the hospital. This information could not be provided. On 11/14/19 at 4:27 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information could be presented prior to exit. 4. Resident #55 was originally admitted to the facility on 10/30/17 and readmitted on 10/10/19. The current diagnoses included: Hypercalcemia and Alzheimer's disease. The quarterly Minimum Data Set (MDS) an	F 625		

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F 625	Continued From page 52 admissions assessment with an assessment reference date (ARD) of 10/17/19, coded the resident with a 6 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating Cognitive skills for decision making shows resident as being severely impaired for daily decision making. Review of the clinical record revealed a nurse's note dated 11/04/19 at 12:36 AM which included that the Resident's Daughter was present in the room and updated about transfer to the hospital. Left via stretcher at 8 PM was awake and alert at that time. No documentation was observed in the clinical record which stated the facility staff provided written information about the bed hold notice to the resident and/or the resident representative prior to and/or upon transfer or within 24 hours. The above findings were shared with the Administrator and Director of Nursing (DON) on 11/14/19 at approximately 4:30 PM. The DON stated that no bed hold notice was issued.	F 625		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments.	F 640	1. MDS discharge assessment was completed for resident #2. 2. All residents who discharge from the facility are at risk for not having a discharge assessment completed. 3. MDS Team lead will educate the MDSC's on the importance of completing timely discharge assessments.	

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F 640	Continued From page 53 (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 640	4. MDSC's will conduct bi-weekly audits for all discharged residents x 2 months to ensure a discharge assessment was completed. The results of the audits will be shared with the QAPI team. 5. Date of Completion December 27, 2019	

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F 640	Continued From page 54 Based on staff interview and clinical record review the facility staff failed to ensure a discharge assessment (MDS) was completed for 1 of 38 residents (Residents #2), in the survey sample. The findings included: The facility staff failed to complete a discharge MDS assessment for Resident #2. Resident #2 was discharged from the facility and admitted to another nursing facility on 07/18/19. The diagnoses for Resident #2 included but not limited to Dislocation of the right hip. Resident #2's last Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date of 07/25/19 coded Resident #2's Brief Interview for Mental Status (BIMS) scoring a 15 out of a possible 15 indicating no cognitive impairment. In addition, the MDS coded Resident #2 requiring total dependence of one with transfer, dressing, bathing and toilet use, extensive assistance of one with personal hygiene and bed mobility for Activities of Daily Living (ADL) care. Review of Resident #2's clinical note dated 07/18/19 read in part: Resident discharged to another facility via transport in a wheel chair. Resident stable upon discharge. An interview was conducted with MDS Coordinator #1 on 11/14/19 at approximately 3:25 p.m. She reviewed Resident #2's clinical record then stated, "Resident #2 was discharged to another facility on 07/18/19." She said a discharge MDS was not completed." She said I will do a discharge MDS assessment right now.	F 640		

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F 640	Continued From page 55 On the same day at approximately 4:10 p.m., the MDS Coordinator presented a validation report of the transmission of the assessment showing a discharge MDS was created on 11/14/19 for a discharge out of the facility on 07/18/19. A briefing was held with the Administrator and Director of Nursing on 11/14/19 at approximately 4:25 p.m. The facility did not present any further information about the findings. CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI). -Discharge Assessment-return not anticipated: Must be completed when the resident is discharge from the facility and the resident is not expected to return to the facility within 30 days. -Must be completed (Item Z0500B) within 14 days after the discharge date (A200 + 14 calendar days). -Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure that 1 of 38 residents (Resident #30) in the survey sample received a complete and accurate Minimum Data Set (MDS) assessment. Resident #30's quarterly MDS assessment with an Assessment Reference Date (ARD) of 09/09/19 was coded incorrectly under Section G	F 641	1. MDS was corrected in section G to include impairment on one side of upper and lower extremity for resident #30 on 11/13/19 prior to survey team exiting the building. 2. All residents have the potential to be affected when MDS assessments are not accurate. 3. The MDS Team Leader will educate MDS staff on importance of timely and accurate completion of MDS assessments.	

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F 641	Continued From page 56 (Functional Limitations of Range of Motion). The findings included: Resident #30 was originally admitted to the facility on 12/18/15. Diagnoses for Resident #30 included but not limited to Cerebrovascular Accident (CVA-stroke) with left hemiparesis (weakness on one side of the body). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 09/09/19 coded the Resident #30 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #30 requiring total extensive assistance of one with transfer, dressing, personal hygiene, bathing, toilet use and bed mobility for Activities of Daily Living (ADL) care. Review of Resident #30's quarterly MDS assessment with the ARD of 09/09/19, under (Functional Limitation in Range of Motion) was coded for no impairment to Resident #30's upper or lower extremity. Resident #30's comprehensive care plan with a revision date of 09/12/19 documented resident with self-care deficit - assistance required with bathing, hygiene dressing and grooming related to left hemiparesis status post CVA. The goal: resident will continue to assist with ADL care as able with staff assist. Some of the interventions to manage goals include but not limited to provide hands on assist for affected side. On 11/12/19 at approximately 11:21 a.m., an interview was conducted with Resident #30.	F 641	4. MDS will conduct bi-weekly audits of 10% of quarterly MDS's X 2 months for the residents' functional status. The results of the audits will be shared with QAPI team. 5. Date of Completion December 27, 2019	

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F 641	Continued From page 57 During the interview, Resident #30 used her right hand to remove her left hand from underneath her bed covers. Resident #30 stated "I haven't been able to move my left side like anything since my stroke years ago." An interview was conducted with MDS Coordinator on 11/13/19 at approximately 9:05 a.m. She reviewed the quarterly MDS with the ARD of 09/09/19 and stated "I think the MDS may have been coded incorrectly, but I will do an assessment on Resident #30 and get back with you." On the same day at approximately 9:25 a.m., the MDS Coordinator stated "I assessed Resident #30 for ROM (range of motions) limitations, the MDS for 09/09/19 was coded incorrectly." She said Resident #30 has ROM (limitation) to her left side (upper and lower extremity). The MDS Coordinator stated, "I will modify the 09/09/19 quarterly MDS and correct section the under functional limitation in range of motion to include limitations on one side to both upper and lower extremity." A briefing was held with the Administrator and Director of Nursing on 11/14/19 at approximately 4:25 p.m. The facility did not present any further information about the findings. CMS' RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident	F 641		

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F 641	Continued From page 58 interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	1. The care plans for residents #6 and #28 were updated to include anticoagulation use. The care plan for resident #47 was updated to include the use of a psychotropic medication. The care plan for resident #45 was updated to reflect accurate ADL needs. The care plan for resident for resident #31 was updated to include interventions for diabetes 2. Residents who are receiving antipsychotic or anticoagulation medication, who have a diagnosis of diabetes, or who require assistance with ADL' S are at risk for not having a care plan that is person centered. 3. Staff will be educated on what should be included in a comprehensive person centered care plan and the importance of the care plan accurately reflecting the resident's current status. 4. A 100 % audit of current resident care 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	

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F 656	Continued From page 59 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to develop a comprehensive care plan for 5 of 38 residents (Resident #6, #45, #47, #28 and #31) in the survey sample. The findings included: Facility policy titled, "Comprehensive Care Plan" documented the following: "Purpose: establishment, periodic review of current patient-centered plan of care for each resident to assure a systematic, comprehensive approach to assessing, planning, and periodic review in meeting resident's needs...Comprehensive Care Plan will: Identify problem areas and address associated risk factors, Culturally competent and trauma-informed if applicable, Sound and established goals, timetables, and objectives monitored through measurable objectives and outcomes." 1. The facility staff failed to develop a care plan for Resident #6 who was receiving an anticoagulation medication (Coumadin-blood thinner). Resident #6 was originally admitted to the nursing facility on 11/23/15. Diagnoses	F 656	conduct weekly audits of 10% of resident care plans X 90 days to ensure it is person centered. Audits result will be shared with QAPI committee. 5. Date of Completion December 27, 2019	

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F 656	Continued From page 60 included but not limited to, Acute Embolism and Thrombus of right lower extremity. The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 08/01/19 coded the resident with a 00 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The residents MDS was coded for the usage of anticoagulant. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an anticoagulant for 7 days. The review of Resident #6's Physician Order Sheet (POS) indicated the original order for Coumadin was started on 01/31/19; Resident #6's comprehensive care plan did not include a care plan for the use of an anticoagulation medication. An interview was conducted with MDS Coordinator #1 on 11/13/19 at approximately 11:55 a.m. She reviewed Resident #6's, MDS with an ARD date of 08/01/19, current physician orders and her care plan. When asked if there should have been an anticoagulation care plan created since the resident was taking the medication Coumadin, she replied, "Yes, it appears we did not put an anticoagulation care plan in place." She said, "I will develop an anticoagulation care plan now." An anticoagulation care plan was given to the surveyor that was created on 11/13/19 at 4:40 p.m., but only created after it was requested by the surveyor from the MDS Coordinator on	F 656		

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	495392	A. BUILDING _____ B. WING _____	11/14/2019

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F 656	Continued From page 61 11/13/19 at 11:55 a.m. The review of the anticoagulation care plan included but not limited to following information: Resident is at risk for adverse bleeding related to anticoagulant /Coumadin use to manage a diagnosis of Deep Vein Thrombus (DVT - blood clot). Goal: to prevent and promptly detect and report bleeding over the next review period 1/10/20. Some interventions to manage goal include but not limited to: give medication as ordered, report bruising or bleeding to charge nurse, monitor for signs and symptoms (s/s) of bleeding, review quarterly in care plans, monitor labs as ordered and to make physician aware of abnormal lab results and complaints. A briefing was held with the Administrator and Director of Nursing on 11/14/19 at approximately 4:25 p.m. The facility did not present any further information about the findings. 2. Facility staff failed to develop an ADL (activities of daily living) functional status care plan for Resident #45. 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 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. In Section V (Care Area Assessment) (CAA)	F 656		

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F 656	Continued From page 62 Summary, care area "ADL Functional/Rehabilitation Potential" was triggered on the assessment. A "1" was coded under Section B. "Care Planning Decision" indicating this care area would be care planned. Review of Resident #45's comprehensive care plan dated 10/8/19 failed to reflect Resident #45's ADL status. Review of Resident #45's November 2019 CNA (Certified Nursing Assistant) -ADL tracking form revealed that Resident #45 was extensive assist to totally dependent on one staff member with most ADLs. Resident #45 needed supervision only with meals. On 11/14/19 at 3:19 p.m., an interview was conducted with OSM (other staff member) #1, the MDS nurse. When asked what a "one" means under Section B "Care Planning Decision" of the CAA summary, OSM #1 stated that a "one" indicated that that triggered area would be care planned. When asked if ADL function should be care planned for Resident #45, OSM #1 stated that ADL function was typically on every care plan to inform staff on how to provide assistance with resident care. OSM #1 confirmed that ADL function was missing from Resident #45's care plan. OSM #1 stated, "It's not there." 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. 3. Facility staff failed to develop a care plan to reflect the use of an antipsychotic medication for Resident #47.	F 656		

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F 656	Continued From page 63 Resident #47 was admitted to the facility on 7/17/19 with diagnoses that included, but were not limited to, Dementia without behavioral disturbance, Alzheimer's disease with late onset, mental disorder and anxiety disorder. Resident #47's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/8/19. Resident #47 was coded as being severely impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded in Section D (Mood) as having a mood score of 00. Resident #47 was coded in Section E0200 (Behaviors) as having one episode of verbal behaviors. Resident #47 was coded in Section I (Active Diagnoses) as having Dementia. Resident #47 was not coded as having any active psychiatric or mood disorders. Resident #47 was coded in Section N (Medications) as receiving an antipsychotic for 7 days during the seven day look back period. Review of Resident #47's November 2019 POS (physician order summary) revealed that Resident #47 was on the following medication: 1) Olanzapine (Zyprexa) (1) 2.5 mg (milligrams) Tablet oral for Mental Disorders Frequency Hour of Sleep." This order was initiated upon admission on 7/17/19. There was no evidence in Resident #47's clinical record indicating what "Mental Disorder" Resident #47 had. Review of Resident #47's hospital discharge instructions dated 7/17/19, failed to evidence an appropriate diagnosis for the use of Zyprexa. The following was documented: "Continue these	F 656		

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F 656	Continued From page 64 medications which have not changed...Olanzipine 2.5 mg PO (by mouth) TABS (tablets)." Review of Resident #47's comprehensive care plan dated 8/6/19 and revised 10/18/19 failed to reflect that Resident #47 was taking an antipsychotic, targeted behaviors associated with antipsychotic use and an appropriate diagnosis for the use of an antipsychotic. Review of Resident #47's clinical record failed to evidence any behavior monitoring. On 11/14/19 at 10:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manger. When asked if a resident is on a psychotropic drug, should that medication be reflected on the care plan, RN #1 stated that all psychotropic drugs should be addressed on the care plan to alert staff to monitor for targeted behaviors, side effects of the medication etc. When asked the purpose of the care plan, RN #1 stated that the care plan was personalized to identify specific needs of each resident. On 11/14/19 at 11:46 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4, the nurse who frequently cared for Resident #47. When asked if Resident #47 ever exhibited any behaviors, LPN #4 stated that sometimes Resident #47 was worried when she didn't understand something about her care, but she wouldn't say Resident #47 had anxiety. LPN #4 stated, "It's more if she's confused about a treatment she harps on it until she gets all the answers." When asked why Resident #47 was taking Zyprexa, LPN #4 stated she was not sure why she was on Zyprexa and she was not aware that she had to monitor for any targeted/specific	F 656		

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F 656	Continued From page 65 behaviors. When asked if she usually monitors behaviors for Residents on antipsychotics, LPN #4 stated that she would monitor for behaviors specific to that person. When asked she would know to monitor for behaviors, LPN #4 stated that she would get that information in report and it should be documented on the care plan. 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 was presented prior to exit. (1) Zyprexa "atypical antipsychotic that is used currently in the treatment of schizophrenia and bipolar illness." This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Zyprexa. 4. For Resident #28, the facility staff failed to develop a comprehensive person-centered care plan to include anticoagulant medication. Resident #28 was admitted to the facility on 08/02/2018. Diagnoses included but were not limited to, Atrial Fibrillation and Diabetes Mellitus. Resident #28's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 09/07/2019 was coded with a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. In addition, the MDS coded Resident #28 as requiring limited assistance of 1 with dressing and personal hygiene, extensive assistance of 1 with bed mobility, transfer and toilet use and total dependence of 1 with bathing.	F 656		

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F 656	Continued From page 66 On 11/14/2019 review of Resident #28's MDS in Section N under "Medications Received" read as follows: "Indicate the number of days the resident received the following medications during the last 7 days ....." The MDS was coded for receiving anticoagulant for 7 days. Review of Resident #28's Physician Order Sheet on 11/14/2019 revealed an order for "Xarelto 20 MG (Milligram) tablet 1 tab (Tablet) Oral - One Time Daily." Order Date: 08/05/2019. On 11/14/2019 review of Resident #28's comprehensive care plan did not include a care plan for the use of an anticoagulant. On 11/14/2019 at approximately 1:29 p.m., an interview was conducted with MDS Coordinator #1 and she was asked, "Is Resident #28 on an anticoagulant?" MDS Coordinator #1 stated, "Yes." When asked if the anticoagulant on the resident's care plan, MDS Coordinator #1 stated, "No. It should be on his care plan. I will revise the care plan and provide you a copy of the updated care plan." MDS Coordinator #1 was asked, "What is the purpose of the care plan?" MDS Coordinator #1 stated, "It's what we use to know what care to provide to the resident." 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. Definitions: * Xarelto - Xarelto is approved by the FDA (Food and Drug Administration) to help reduce the risk of blood clots in common conditions like atrial	F 656		

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F 656	Continued From page 67 fibrillation (Afib), deep vein thrombosis (DVT), and pulmonary embolism (PE). It is also approved for conditions for which no other anticoagulant has been approved before, such as coronary artery disease (CAD) and peripheral artery disease (PAD). Important Safety Information: Xarelto may cause serious side effects, including: Increased risk of bleeding. Xarelto can cause bleeding which can be serious, and may lead to death. This is because Xarelto is a blood thinner medicine (anticoagulant) that lowers blood clotting. During treatment with Xarelto you are likely to bruise more easily, and it may take longer for bleeding to stop. You may be at higher risk of bleeding if you take Xarelto and have certain other medical problems. (https://www.xarelto-us.com/). 5. For Resident #31, the facility staff failed to develop a comprehensive person-centered care plan to include Diabetes Mellitus. Resident #31 was admitted to the facility on 11/04/2015. Diagnoses included but were not limited to, Type 2 Diabetes Mellitus* without complications and Vascular Dementia. Resident #31's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 09/04/2019 was coded with a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. In addition, the MDS coded Resident #31 as requiring limited assistance of 1 with eating, total dependence of 1 with dressing, toilet use, personal hygiene and bathing, and total dependence of 2 with bed mobility and transfer.	F 656		

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F 656	Continued From page 68 On 11/14/2019 review of Resident #31's Physician Order Sheet for November 2019 revealed the following: "Trulicity 0.75 mg (Milligram)/0.5 ml (Milliliter) subcutaneous pen injector (0.75 mg) Pen Injector (ML) Subcutaneous Frequency: One Time Weekly. ICD - 10 E11.9 - Type 2 Diabetes Mellitus without complications." Order Date: 08/09/2019. Review of Resident #31's comprehensive person-centered care plan on 11/14/2019 did not reveal a care plan for Diabetes Mellitus. On 11/14/2019 at 3:30 p.m., an interview was conducted with MDS Coordinator #1 and she was asked if Resident #31 had a diagnosis of Diabetes Mellitus. MDS Coordinator #1 stated, "Yes." MDS Coordinator #1 was asked if Diabetes Mellitus was addressed in his care plan; the MDS Coordinator stated, "No, nothing." When asked if Diabetes Mellitus should be included in his care plan, MDS Coordinator #1 stated, "Yes. I will revise his care plan and provide you a copy." MDS Coordinator #1 was asked what the purpose of the care plan is. MDS Coordinator #1 stated, "It's what we use to know what care to provide to the resident." 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. Definitions: * Type 2 Diabetes Mellitus - Diabetes means your blood glucose, or blood sugar, levels are too high. With type 2 diabetes, the more common type, your body does not make or use insulin well.	F 656		

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F 656	Continued From page 69 Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. Over time, high blood glucose can lead to serious problems with your heart, eyes, kidneys, nerves, and gums and teeth. (https://medlineplus.gov/diabetes.type2.html) * Trulicity - Once weekly Trulicity is not insulin. It helps your body do what it is supposed to do naturally-release its own insulin, responding when your blood sugar rises. It's used along with diet and exercise to help lower your blood sugar and A1C numbers. Serious side effects: Low blood sugar (hypoglycemia) - Signs and symptoms of low blood sugar may include dizziness or light headedness, confusion or drowsiness, headache, blurred vision, slurred speech, fast heartbeat, sweating, hunger, shakiness, feeling jittery, weakness, anxiety, irritability or mood changes. Common side effects: The most common side effects of Trulicity include nausea, diarrhea, vomiting, abdominal pain and decreased appetite. (https://www.trulicity.com/about-trulicity/)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	1. The care plan for resident #40 was revised to include DNR status. The care plan for resident #14 was revised to include monitoring interventions related to a recent incident involving unwanted sexual advances from another resident. 2. All residents have the potential to be affected when care plans are not updated timely.	

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F 657	Continued From page 70 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to revise the comprehensive care plan for 2 of 38 residents in the survey sample, Residents #40 and #14. The findings included: 1. The facility staff failed to revise Resident #40's care plan to include a DNR (do not resuscitate) order. Resident #40 was admitted to the facility on 09/17/2019 with diagnoses that included but were not limited to, Chronic Kidney Disease, Stage 3 and Acute Diastolic (Congestive) Heart Failure. Resident #40's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 09/24/2019 coded Resident #40 with a BIMS (Brief Interview of Mental Status) score of 08 indicating moderate cognitive	F 657	3. 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. 4. A 100% audit on every resident's care plan will be conducted to ensure code status on the resident care plan is accurate. Interdisciplinary team will 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. 5. Date of Completion December 27, 2019	

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F 657	Continued From page 71 impairment. In addition, the Minimum Data Set coded Resident #40 as requiring total dependence of 1 with transfer, dressing, toilet use, personal hygiene and bathing and total dependence of 2 with bed mobility. On 11/13/2019 Resident #40's Comprehensive Care Plan was reviewed and revealed the following: "(Resident Name) is a Full Code." On 11/14/2019 review of Resident #40's Physician Order Sheet For November 2019 revealed the following order: "Do Not Resuscitate" Order Date: 11/06/2019. On 11/14/2019 at approximately 9:00 a.m., a copy of Resident #40's Advance Directives was requested and at approximately 11:00 a.m., a copy of Resident #40's Advance Medical Directive and a "Durable Do Not Resuscitate Order" dated 11/06/2019 was received. An interview was conducted with the Director of Nursing (DON) on 11/14/2019 at 4:00 p.m. and she was asked what Resident #40's code status was. The DON stated, "She has an order for Do Not Resuscitate." Resident #40's care plan was reviewed with the DON. The DON stated, "The care plan should have been revised and changed to "Do Not Resuscitate." The Administrator and Director of Nursing were 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. For Resident #14, facility staff failed to revise her care plan after she was involved in an incident of inappropriate sexual behaviors from	F 657		

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F 657	Continued From page 72 Resident #44 on 8/30/19. Resident #14 was admitted to the facility on 11/14/13 with diagnoses that included but were not limited to dementia with behavioral disturbance and muscle weakness. Resident #14's most recent MDS assessment was a quarterly assessment with an ARD (assessment reference date) of 8/20/19. Resident #14 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded in Section B as sometimes being understood by staff and sometimes understanding staff. Resident #14 was coded as requiring extensive assistance with 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 ARD (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 (Brief 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 #14's nursing notes documented two incidents of sexual behaviors	F 657		

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	495392	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING AND REHAB CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

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F 657	Continued From page 73 from Resident #44. The following notes were documented in Resident #14's chart: "8/30/19: At 21:10 (9:10 p.m.) this nurse was frantically grabbed by CNA (certified nursing assistant) and asked for my help. I was brought to resident's room to find another resident (Resident #44) face down on top of her legs with her brief undone. Other resident was assisted off this resident. Resident was given a full skin inspection; resident did not grimace or complain of pain during inspection. Will continue to monitor for possible injury." "8/30/19 at 1120 p.m.: 2 staff observed another resident (Resident #44) in wheelchair at bedside placing paper object into her mouth. When investigated- there was a ten-dollar bill in resident's mouth, which was removed whole. No s/s (signs and symptoms) SOB (shortness of breath) or difficulty breathing. On examination, resident appears to have no apparent injury from either incident. Very awake, and alert with confusion. Talking to herself, and able to move all extremities with no c/o (complaints) of discomfort. Will continue to monitor closely." Review of Resident #14's comprehensive care plan dated 8/21/19 revealed that her care plan was not revised to reflect this incident with Resident #44 (Resident #44's care plan was revised). On 11/14/19 at 10:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. The interview is documented in part: When asked the process if she were to find a resident on top of another resident with their brief undone, RN #1 stated that she would	F 657		

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F 657	Continued From page 74 immediately separate the residents, do an assessment on both residents "looking for any signs of physical issues...RN #1 stated that she would document the incident in a progress notes as well as the head to toe assessment. RN #1 stated that the care plan should also be revised for both residents to alert staff on the incident between the two residents. When asked the purpose of the care plan, RN #1 stated that the care plan was personalized to identify specific needs of each resident. RN #1 stated that the care plan should be revised if needed. When asked who could revise the care plan, RN #1 stated that any floor nurse could revise the care plan as well as MDS. On 11/14/19 at 4:27 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Lewy body dementia "(LBD) is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. Lewy body dementia is one of the most common causes of dementia." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/what-lewy-body-dementia#what.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677	1. Resident #45 fingernails were trimmed prior to survey team exiting the building	

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F 677	Continued From page 75 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to provide fingernail care for a dependent resident for one of 38 residents in the survey sample, Resident #45. The findings included: 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, cervical spinal cord injury, and polyneuropathy (1). 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 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 expressed concern that he would like his nails cut and that the staff did not cut nails. Resident #45 stated that staff never offer to cut his nails. When asked if he was able to cut his own nails, Resident #45 stated that he may be able to but that his hands are stiff and was	F 677	2. All residents who are require assistance with nail care are at risk when nail care is not provided. 3. Nursing staff will be educated on the process for providing resident nail care. 4. A 100% audit of all current residents will be conducted to ensure nails are clean and trimmed. Clinical Manager or designee will conduct audits of resident's nails 3 x weekly for 4 weeks, 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. 5. Date of Completion December 27, 2019	

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F 677	Continued From page 76	F 677		

sometimes hard to move his fingers or open his hands. When asked if he has asked staff to cut his nails, Resident #45 stated that the staff wouldn't do it if he asked. An observation was made of Resident #45's fingernails at that time. His nails on both hands were approximately 1/2 inch long. Resident #45 had black debris under the left thumbnail.

Review of Resident #45's CNA (certified nursing assistant) -ADL tracking form, revealed a section that documented "Nail Care." This section was blank for the months of October and November 2019.

On 11/14/19 at 10:20 a.m., an interview was conducted with Registered Nurse (RN) #1, the unit manager. When asked who was responsible for providing nail care including cutting fingernails, RN #1 stated that CNA (certified nursing assistants) can cut fingernails if the resident was not diabetic. When asked when fingernails were cut, RN #1 stated that she was not sure. RN #1 stated that if the nurses see that fingernails are long, that they can also cut nails. RN #1 stated that overall the floor nurse was in charge of the resident. When asked if refusals for nail care should be documented, RN #1 stated that the nurse was supposed to document if a resident refuses nail care and the care plan should be revised if the resident frequently refuses nail care.

Review of Resident #45's care plan dated 10/8/19 failed to evidence any refusals of fingernail care. There was no evidence that Resident #45 had an ADL (activities of daily living) care plan.

On 11/14/19 at 10:30 a.m., an interview was

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F 677	Continued From page 77 conducted with CNA #2, the nursing assistant assigned to Resident #45. When asked who was responsible for cutting fingernails, CNA #2 stated that nursing aides did not cut any nails, that the aide alerts the nurse if a resident needs nails cut. When asked if she frequently worked with Resident #45, CNA #2 stated that she usually worked with Resident #45 on weekends and periodically during the week. When asked if she noticed that his fingernails were long, CNA #2 stated that she didn't notice that day but that she had noticed his toenails were very long. When asked the timeframe (approximately how long) Resident #45's toenails were long, CNA #2 stated that she was not sure and that day (11/13/19) was the first day in two weeks she was assigned to Resident #45. On 11/14/19 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #45's assigned nurse. When asked who was responsible for fingernail and toenail care, LPN #2 stated that if a resident is diabetic, they will send the resident out to podiatry as the facility, from what he heard, did not have an in-house podiatrist. LPN #2 stated that nurses can cut fingernails for a diabetic resident. LPN #2 stated that CNAs can also cut fingernails in an non-diabetic resident. When asked who cuts toenails for a resident who is not diabetic, LPN #2 stated that nurses can cut toenails. LPN #2 also stated that sometimes a volunteer group will sometimes come in to do manicures for residents. When asked if he frequently works with Resident #45, LPN #2 stated that he has only been working for a few months and that he has been working with Resident #45 for approximately two weeks. When asked if he had noticed that his fingernails were long, LPN #2	F 677		

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F 677	Continued From page 78 stated that he did not. When asked if he had worked with Resident #45 the day prior 11/13/19 and that day, LPN#2 stated that he has been working with Resident #45 but that he did not notice his fingernails. LPN #2 was then asked to follow this writer to Resident #45's room. On 10:46 a.m., another observation was made of Resident #45's nails. Resident #45's fingernails remained to be 1/2 inch long, this time with no debris underneath the left thumbnail. Resident #45 stated at this time in front of the nurse that he wanted his fingernails cut. On 11/14/19 at 4:27 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing were made aware of the above concerns. Facility policy titled, "Resident Hygiene and Grooming," documents in part, the following: "Staff will ensure that each resident will be: 1. Given proper daily personal attention and care, including skin, nail, and oral hygiene, in addition to any specific care ordered by the attending physician." Provision of daily, personal care will be documented in the clinical record."	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making	F 687	1. The toenails for resident #45 were trimmed prior to survey team exiting the building 2. All residents who require assistance with nail care on feet are at risk when nail care if not provided. 3. Staff will be educated on the process for providing nail care on the feet.	

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F 687	Continued From page 79 appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide podiatry services for one of 38 residents in the survey sample, Resident #45. The findings included: 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, cervical spinal cord injury, and polyneuropathy (1). 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 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 expressed concern that he would like his finger nails cut and that the staff did not cut nails. Resident #45 stated that staff never offer to cut his nails. When asked if he was able to cut his own nails, Resident #45 stated that he may be able to but that his hands are stiff and it was sometimes hard to move his fingers or open	F 687	4. A 100% audit of current resident's toenails will be conducted to ensure nails are clean and trimmed and referrals to podiatry services are made as needed. Clinical Manager or designee will conduct audits of resident's nails 3 x weekly for 4 weeks, then weekly for four weeks, then monthly for two 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. 5. Date of Completion December 27, 2019	

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F 687	Continued From page 80 his hands. When asked if he has asked staff to cut his nails, Resident #45 stated that the staff wouldn't do it if he asked. An observation was made of Resident #45's fingernails at this time. His nails on both hands were approximately 1/2 inch long. Resident #45 had black debris under left thumbnail. Resident #45 did not express any concerns regarding toenails at that time. His feet were covered by his blankets. On 11/14/19 at 10: 30 a.m., an interview was conducted with CNA #2, the nursing assistant assigned to Resident #45. When asked who was responsible for cutting fingernails, CNA #2 stated that nursing aides did not cut any nails, that the aide alerts the nurse if a resident needs nails cut. When asked if she frequently worked with Resident #45, CNA #2 stated that she usually worked with Resident #45 on weekends and periodically during the week. When asked if she noticed that his fingernails were long, CNA #2 stated that she didn't notice that day but that she had noticed his toenails were very long. When asked the timeframe (approximately how long) Resident #45's toenails were long, CNA #2 stated that she was not sure that that day (11/13/19) was the first day in two weeks she was assigned to Resident #45. CNA #2 stated that Resident #45 had just recently that day complained of toenail pain. On 11/14/19 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #45's assigned nurse. When asked who was responsible for fingernail and toenail care, LPN #2 stated that if a resident is diabetic, they will send the resident out to podiatry as the facility, from what he heard, did not have an in-house podiatrist. LPN #2 stated that nurses	F 687		

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F 687	Continued From page 81 can cut fingernails for a diabetic resident. LPN #2 stated that CNAs can also cut fingernails in an non-diabetic resident. When asked who cuts toenails for a resident who is not diabetic, LPN #2 stated that nurses can cut toenails. LPN #2 also stated that sometimes a volunteer group will sometimes come in to do manicures for residents. When asked if he frequently works with Resident #45, LPN #2 stated that he has only been working for a few months and that he has been working with Resident #45 for approximately two weeks. When asked if he had noticed that his toenails were long, LPN #2 stated that he did not. When asked if he had worked with Resident #45 the day prior 11/13/19 and that day, LPN#2 stated that he has been working with Resident #45 but that he did not notice his toenails. LPN #2 was then asked to follow this writer to Resident #45's room. On 10:46 a.m., another observation was made of Resident #45's nails. Resident #45's toenails were observed to be very long and his right toe thumbnail was thickened. At this time Resident #45 was complaining that his right toenail was causing him pain. Resident #45 stated that he didn't know how long it had been since his toenails were cut. On 11/14/19 at 4:27 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Podiatry Services," documents in part, the following: "The facility ensures that podiatry services are available to patients and residents as necessary. The facility will provide or obtain podiatry services as ordered by the attending physician, physician assistant, nurse practitioner, or clinical nurse specialist in	F 687		

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F 687	Continued From page 82 accordance with applicable State law. Qualified personnel means that professional staff are licensed, certified, or registered to provide podiatry care services in accordance with applicable Federal and State laws and professional standards of practice including to minimize complications from the resident's medical condition(s)." (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-Caregiver-Education/Fact-Sheets/Peripheral-Neuropathy-Fact-Sheet.	F 687		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688	1. 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. 2. All residents who require adaptive equipment to maintain range of motion are at risk when the physicians order for the use of the equipment is not followed. 3. Nursing staff will receive education on the importance of using adaptive equipment to maintain ROM and process for reporting and documenting resident refusals.	

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F 688	Continued From page 83 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow physician's orders and plan of care for the application of a hand splint for one of 38 residents in the survey sample, Resident #44. The findings included: Resident #44 was admitted to the facility on 3/23/17 with diagnoses that included but were not limited to post stroke, muscle weakness, Schizophrenia, major depressive disorder, and dementia with Lewy Bodies. Resident #44's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (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 (Brief 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. Resident #44 was coded is Section G0400. (Functional status) as having impairments to one side of the body (upper and lower). Review of Resident #44's Occupational Therapy Discharge Summary revealed that Resident #44 was discharged from therapy services on 5/9/19. The following in part was documented: "PT (patient) and caregiver training: patient's	F 688	4. Clinical Manager will conduct a 100% audit of current residents who currently have physician's orders for adaptive equipment to ensure physician's orders are being followed. Clinical Manager or designee will conduct ongoing audits of physician orders to ensure the use of adaptive equipment as ordered or documentation of the resident's refusal. Audits to be conducted 3 x weekly for 4 weeks, then weekly for four weeks, then monthly for two months. Audit will be shared with QAPI committee with revisions to action plan as needed based on results. 5. Date of Completion December 27, 2019	

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	495392	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING AND REHAB CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 84 caregivers engaged in education on proper donning/doffing split (sic) and importance of skin integrity checks. Discharge Recommendations: 24 hour care and Splint/brace...RNP (restorative nursing program) n/a (not applicable). Review of Resident #44's November 2019 POS (physician order summary) documented the following active order: "Apply hand roll to right hand in AM & (and) take off during evening hours R/T (related to) contractures." Review of Resident #44's care plan dated 7/23/19 and revised 10/8/19 documented the following: "(Name of Resident #44) has contracture of right hand and right side weakness...Hand roll to right hand." On 11/13/19 at 9:53 a.m., 10:12 a.m., 12:17 p.m., 1:36 p.m., and 3:00 p.m. observations were made of Resident #44. She did not have her hand roll in place to her right hand. There was no evidence in the clinical record that she refused her hand roll (splint) that day. There was no evidence in Resident #44's care plan that she refused the hand roll or removed the hand roll. Review of Resident #44's November 2019 TAR (treatment administration record) revealed that Resident #44's nurse had documented that Resident #44's right hand splint was in place during the day shift on 11/13/19. On 11/14/19 at 11:34 a.m., an interview was conducted with CNA (certified nursing assistant) #3, Resident #44's CNA. When asked who was responsible for putting on splints (hand rolls) on	F 688		

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F 688	Continued From page 85 residents, CNA #3 stated that if a resident is on restorative, the restorative aides place the splints or the assigned nursing aide can place the splints. CNA #3 stated that Resident #44 was on restorative for ambulation and that her regular assigned aide (usually CNA #3) places her splint. When asked if Resident #44 had her right hand splint in place on 11/13/19, CNA #3 stated that Resident #44 has refused so much in the past that she stopped offering to place it on Resident #44. CNA #3 stated that she did not even offer on 11/13/19 to place her hand splint. When asked the process if a resident continues to refuse hand splints, CNA #3 stated that she would alert the nurse. CNA #3 stated that she was not even sure if Resident #44 still had an active order for the hand splint. When asked how CNAs are made aware of any changes in a residents status such as pertinent orders, CNA #3 stated she is made aware in a verbal report, that she did not have a CNA guide or reference to check to see if a resident had an active order for splints. CNA #3 stated that she did not have access to the care plan. On 11/14/19 at 11:40 a.m., an interview was conducted with a nurse on the unit, LPN (Licensed Practical Nurse) #4. When asked who was responsible for ensuring splints were in place, LPN #4 stated that it was ultimately the nurses responsibility for ensuring splints are in place per physician's order. LPN #4 stated that nursing aides may be able to place a splint depending on the order. When asked how nursing aides were made aware that a splint needs to be put on a resident, LPN #4 stated that it should be on the ADL (activities of daily living) chart for that specific resident. LPN #4 stated that the ADL chart was a guide for CNAs to follow on	F 688		

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F 688	Continued From page 86 how to care for each resident. LPN #4 stated that the ADL guides were kept at the nurses station. On 11/14/19 at 11:45 a.m., Resident #44's ADL chart dated 11/2019, did not address her right hand splint. On 11/14/19 at 11:56 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked who was responsible for ensuring a splint was in place per physician's order, RN #1 stated that she was not sure if nursing aides were able to place splints, but that the nurse was ultimately responsible. RN #1 confirmed that a splint should be on if there is a physician's order for to to be on. RN #1 stated that if a resident refuses to wear a splint, it must be clearly documented in the clinical record and care planned if refusals are frequent. RN #1 stated that frequent refusals may indicate that the order needs to be changed. RN #1 stated that she was not familiar with Resident #44. On 11/14/19 at approximately 2:00 p.m., an interview was conducted with LPN #2, Resident #44's nurse. When asked who was responsible for placing and splints on residents, LPN #2 stated that the CNAs will put on splints. When asked about Resident #44's hand splint, LPN #2 stated, "CNAs put it on in the morning if she lets them." When asked if she was wearing her hand splint on 11/13/19, LPN #2 stated that he was not sure if she was wearing it. LPN #2 stated that if he documented on the TAR (treatment administration record) that she was wearing it then she was. When told LPN #2 about the above observations and that her assigned CNA did not offer to place the splint, LPN #2 stated that his documentation on the November TAR must have	F 688		

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F 688	Continued From page 87 been an accident. When asked if he placed her splint, LPN #2 stated that he did not. LPN #2 also stated that Resident #44 did not put her splint on herself. On 11/14/19 at 4:27 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing were made aware of the above concerns. A facility policy was requested but not received.	F 688		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	1. The psychotropic medication for Resident #47 was reviewed by the attending physician. 2. All residents who are receiving psychotropic medication are at potential risk for receiving unnecessary medication. 3. Nursing staff will be educated on the need for a proper diagnosis for the use of psychotropic medications. 4. Clinical Manager or designee will conduct a 100% audit of all current residents who are receiving psychotropic medication to ensure there is a proper diagnosis for the use of the medication. All new admissions and current residents who are receiving psychotropic medication will be discussed at the weekly resident at risk meetings to determine if there is a proper diagnosis for the use of the medication. Facility will follow pharmacy consultant recommendations regarding gradual dose reductions.	

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F 758	Continued From page 88 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure one of 38 sampled residents, Resident #47, was free from unnecessary psychotropic drugs. The findings included: Resident #47 was admitted to the facility on 7/17/19 with diagnoses that included but were not limited to Dementia without behavioral disturbance, Alzheimer's disease with late onset, mental disorder and anxiety disorder. Resident #47's most recent MDS (Minimum Data Set) assessment was a quarterly assessment was an ARD (assessment reference date) of 10/8/19.	F 758	Results of audit will be shared with QAPI committee. 5. Date of Completion December 27, 2019	

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F 758	Continued From page 89 Resident #47 was coded as being severely impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded in Section D (Mood) as having a mood score of 00. Resident #47 was coded in Section E0200 (Behaviors) as having one episode of verbal behaviors. Resident #47 was coded in Section I (Active Diagnoses) as having Dementia. Resident #47 was not coded as having any active psychiatric or mood disorders. Resident #47 was coded in Section N (Medications) as receiving an antipsychotic for 7 days during the seven day look back period. Review of Resident #47's November 2019 POS (physician order summary) revealed that Resident #47 was on the following medication: 1) Olanzapine (Zyprexa) (1) 2.5 mg (milligrams) Tablet oral for Mental Disorders Frequency Hour of Sleep." This order was initiated upon admission on 7/17/19. There was no evidence in Resident #47's clinical record indicating what "Mental Disorder" Resident #47 had. Review of Resident #47's hospital discharge instructions dated 7/17/19, failed to evidence an appropriate diagnosis for the use of Zyprexa. The following was documented: "Continue these medications which have not changed...Olanzipine 2.5 mg PO (by mouth) TABS (tablets)." Review of Resident #47's comprehensive care plan dated 8/6/19 and revised 10/18/19 failed to reflect that Resident #47 was taking an antipsychotic, targeted behaviors associated with antipsychotic use and an appropriate diagnosis for the use of an antipsychotic. Review of	F 758		

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F 758	Continued From page 90 Resident #47's clinical record failed to evidence any behavior monitoring. Review of Resident #47's monthly pharmacy reports since August 2019, revealed no irregularities. On 11/14/19 at 10:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manger. When asked the process if a resident is admitted to the facility on an anti-psychotic medication, RN #1 stated that if a resident is admitted to the facility on an anti-psychotic, nursing will first ensure a proper diagnosis is attached to the order. RN #1 stated that an AIMS (abnormal involuntary movement scale) assessment will also be completed to determine if the resident is presenting with any long term side effects from the use of anti-psychotics and if these side effects are the resident's baseline. RN #1 stated that nursing staff should "Do a deeper dive to see how long the resident has been on an anti psychotic." When asked if nursing should monitor for behaviors or any targeted behaviors for the use of the anti-psychotic, RN #1 stated that every nursing unit has behavioral monitoring sheets for each resident who is on psychotropic drugs. RN #1 stated that behaviors should be documented if a resident is exhibiting a behavior. When asked if a resident is on a psychotropic drug, if that medication should be reflected on the care plan, RN #1 stated that all psychotropic drugs should be addressed on the care plan to alert staff to monitor for behaviors, side effects of the medication etc. When asked what the diagnosis of "Mental Disorder" means, RN #1 stated that this diagnosis should be clarified. RN #1 stated that Mental Disorder could mean anything. RN #1	F 758		

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F 758	Continued From page 91 stated that there has to be a specific diagnosis for the use of an anti-psychotic. When asked if she knew why Resident #47 was on Zyprexa, RN #1 stated that she was not familiar with Resident #47 and was not sure. RN #1 was asked to find out why Resident #47 was on Zyprexa and any behavior monitoring sheets she could find. On 11/14/19 at 11:15 a.m., further interview was conducted with RN #1. RN #1 presented a behavior monitoring sheet dated 11/2019 that documented the following targeted behavior "delusions." RN #1 stated that she still could not figure out why Resident #47 was on Zyprexa. When asked what Resident #47's delusions were, RN #1 stated she didn't know. "zeros" were documented on her behavior monitoring sheet indicating that Resident #47 did not have any delusions in November so far. When asked about Resident #47's other behavior monitoring sheets, RN #1 stated she could only find November so far. On 11/14/19 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3, Resident #47's frequent CNA. When asked if Resident #47 had exhibited any behaviors since her admission, CNA #3 stated that maybe one time Resident #47 hollered at friends visiting but was not aware of any other behaviors. CNA #3 stated that she was not aware that she had to monitor for any type of behaviors for Resident #47. On 11/14/19 at 11:46 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4, Resident #47's frequent nurse. When asked if Resident #47 ever exhibited any behaviors, LPN #4 stated that sometimes Resident #47 was	F 758		

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F 758	Continued From page 92 worried when she didn't understand something about her care, but she wouldn't say Resident #47 had anxiety. LPN #4 stated, "It's more if she's confused about a treatment she harps on it until she gets all the answers." When asked why Resident #47 was taking Zyprexa, LPN #4 stated she was not sure why she was on Zyprexa and she was not aware that she had to monitor for any targeted/specific behaviors. When asked if she usually monitors behaviors for Residents on antipsychotics, LPN #4 stated that she would monitor for behaviors specific to that person. When asked she would know to monitor for behaviors, LPN #4 stated that she would get that information in report and it should be documented on the care plan. On 11/14/19 at 11:55 a.m., RN #1 presented the rest of Resident #47's behavior monitoring sheets August 2019 through October 2019. Review of the behavior monitoring sheets revealed that Resident #47 had no delusions. On 11/14/19 at 12:50 p.m., an interview was conducted with ASM (administrative staff member) #3, Resident #47's physician and the medical director. When asked why Resident #47 was taking Zyprexa, ASM #3 stated that she was discharged from the hospital on the medication. ASM #3 checked the hospital computer system with this writer and found that between 2017 and 2018, Resident #47 was placed on the medication (not in the facility) and was on it prior to her recent hospital admission. ASM #3 stated that Resident #47 was on the medication for a long period of time and was doing well so he did not see a reason to change it and stated "Why, someone started her on it, I don't know." When asked what targeted behaviors staff should be	F 758		

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F 758	Continued From page 93 monitoring Resident #47 for, ASM #3 stated that Resident #47 had dementia and some memory deficits, but it was hard to say what her behaviors were because she hadn't displayed any behaviors. ASM #3 stated that if they stopped the medication, whatever behaviors she had prior to admission may come back. ASM #3 stated, "Why mess with it?" ASM #3 stated that he could get (name of a psych group) to come in and evaluate Resident #47 but that it was hard to get psych into nursing facilities. ASM #3 then stated that maybe the psych group should come in if there were questions as to why she was taking the medication. ASM #3 stated that maybe he could also talk to the family to see if anyone knew why she was taking the medication. When asked what the diagnosis of "Mental Disorder" means, ASM #3 stated that that diagnosis could mean anything, such as depression. 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. The AIMS assessment could not be provided to this writer for Resident #47. No further information was presented prior to exit. A facility policy could not be provided. (1) Zyprexa "atypical antipsychotic that is used currently in the treatment of schizophrenia and bipolar illness." This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Zyprexa.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	1. The LPN was educated on the importance of accurate documentation in a resident clinical record.	

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F 842	Continued From page 94 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	2. All residents are at risk when the clinical record is inaccurate 3. Nursing staff will be educated on the importance of proper documentation to reflect an accurate clinical record to include the use of adaptive equipment. 4. Clinical Manager or designee will conduct ongoing audits of treatment orders 3x weekly x two weeks, weekly x two weeks, then monthly x two months to ensure accurate documentation of adaptive equipment. Audits results will be shared with QAPI committee and revised as needed. 5. Date of Completion December 27, 2019	

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F 842	Continued From page 95 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review, and clinical record review, it was determined that facility staff inaccurately documented that one of 38 residents (Resident #44), had a right hand roll/splint in use. The findings included: Resident #44 was admitted to the facility on 3/23/17 with diagnoses that included but were not limited to post stroke, muscle weakness, Schizophrenia, major depressive disorder, and	F 842		

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	495392	A. BUILDING _____ B. WING _____	11/14/2019

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F 842	Continued From page 96 dementia with Lewy Bodies. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (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 (Brief 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. Resident #44 was coded is Section G0400. (Functional status) as having impairments to one side of the body (upper and lower). Review of Resident #44's Occupational Therapy Discharge Summary revealed that Resident #44 was discharged from therapy services on 5/9/19. The following in part was documented: "PT (patient) and caregiver training: patient's caregivers engaged in education on proper donning/doffing split (sic) and importance of skin integrity checks. Discharge Recommendations: 24 hour care and Splint/brace...RNP (restorative nursing program) n/a (not applicable). Review of Resident #44's November 2019 POS (physician order summary) documented the following active order: "Apply hand roll to right hand in AM & (and) take off during evening hours R/T (related to) contractures." Review of Resident #44's care plan dated 7/23/19 and revised 10/8/19 documented the following: "(Name of Resident #44) has contracture of right hand and right side weakness...Hand roll to right hand."	F 842		

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F 842	Continued From page 97 On 11/13/19 at 9:53 a.m., 10:12 a.m., 12:17 p.m., 1:36 p.m., and 3:00 p.m. observations were made of Resident #44. She did not have her hand roll/splint in place to her right hand. There was no evidence in the clinical record that she refused her hand roll (splint) that day. There was no evidence in Resident #44's care plan that she refused the hand roll or removed the hand roll. Review of Resident #44's November 2019 TAR (treatment administration record) revealed that Resident #44's nurse had documented that Resident #44's right hand splint was in place during the day shift on 11/13/19. On 11/14/19 at 11:56 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked who was responsible for ensuring a splint was in place per physician's order, RN #1 stated that she was not sure if nursing aides were able to place splints, but that the nurse was ultimately responsible. RN #1 confirmed that a splint should be on if there is a physician's order for to to be on. RN #1 stated that if a resident refuses to wear a splint, it must be clearly documented in the clinical record and care planned if refusals are frequent. RN #1 stated that frequent refusals may indicate that the order needs to be changed. RN #1 stated that she was not familiar with Resident #44. On 11/14/19 at 11:34 a.m., an interview was conducted with CNA (certified nursing assistant) #3, Resident #44's CNA. When asked who was responsible for putting on splints (hand rolls) on residents, CNA #3 stated that if a resident is on restorative, the restorative aides place the splints	F 842		

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F 842	Continued From page 98 or the assigned nursing aide can place the splints. CNA #3 stated that Resident #44 was on restorative for ambulation and that her regular assigned aide (usually CNA #3) places her splint. When asked if Resident #44 had her right hand splint in place on 11/13/19, CNA #3 stated that Resident #44 has refused so much in the past that she stopped offering to place it on Resident #44. CNA #3 stated that she did not even offer on 11/13/19 to place her hand splint. When asked the process if a resident continues to refuse hand splints, CNA #3 stated that she would alert the nurse. CNA #3 stated that she was not even sure if Resident #44 still had an active order for the hand splint. When asked how CNAs are made aware of any changes in a residents status such as pertinent orders, CNA #3 stated she is made aware in a verbal report, that she did not have a CNA guide or reference to check to see if a resident had an active order for splints. CNA #3 stated that she did not have access to the care plan. On 11/14/19 at 11:40 a.m., an interview was conducted with a nurse on the unit, LPN (Licensed Practical Nurse) #4. When asked who was responsible for ensuring splints were in place, LPN #4 stated that it was ultimately the nurses responsibility for ensuring splints are in place per physician's order. LPN #4 stated that nursing aides may be able to place a splint depending on the order. When asked how nursing aides were made aware that a splint needs to be put on a resident, LPN #4 stated that it should be on the ADL (activities of daily living) chart for that specific resident. LPN #4 stated that the ADL chart was a guide for CNAs to follow on how to care for each resident. LPN #4 stated that the ADL guides were kept at the nurses station.	F 842		

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F 842	Continued From page 99 Resident #44 ADL chart dated 11/2019, did not address her right hand splint. On 11/14/19 at approximately 2:00 p.m., an interview was conducted with LPN #2, Resident #44's nurse. When asked who was responsible for placing and splints on residents, LPN #2 stated that the CNAs will put on splints. When asked about Resident #44's hand splint, LPN #2 stated, "CNAs put it on in the morning if she lets them." When asked if she was wearing her hand splint on 11/13/19, LPN #2 stated that he was not sure if she was wearing it. LPN #2 stated that if he documented on the TAR (treatment administration record) that she was wearing it then she was. When told LPN #2 about the above observations and that her assigned CNA did not offer to place the splint, LPN #2 stated that his documentation on the November TAR must have been an accident. When asked if he placed her splint, LPN #2 stated that he did not. LPN #2 also stated that Resident #44 did not put her splint on herself. When asked if nursing should ever document that a treatment or medication was administered when it was not, LPN #2 stated, "I don't know, should it?" LPN #2 then stated that he would find out. On 11/14/19 at 4:27 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled documentation, did not address the above concerns.	F 842		

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F 880 F 880 SS=D	Continued From page 100 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	1. The LPN caring for resident #321 was educated on proper handwashing procedures prior to surveyors exiting the building. Resident #321 was monitored for signs and symptoms of infection with no adverse outcomes noted. 2. All residents receiving blood sugar monitoring procedures are at risk when proper hand hygiene is not followed. 3. Licensed nursing staff will be educated on proper hand washing procedures during blood sugar monitoring. 4. The clinical manager or designee will conduct visual observations 3 x per week x 8 weeks of licensed nursing staff to ensure proper infection control practices are being maintained during blood sugar monitoring procedures. Audit results will be shared with the QAPI team and any further observations of improper infection control practices will result in a modification of the action plan 5. Date of Completion December 27, 2019	

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F 880	Continued From page 101 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to perform appropriate hand hygiene after removing dirty gloves for 1 of 38 residents in the survey sample (Resident #321). The findings included: On 11/13/2019 at 4:36 p.m., Licensed Practical Nurse (LPN) #6 was observed applying clean	F 880		

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F 880	Continued From page 102 gloves and remove a glucometer and blood testing supplies from the medication cart. LPN #6 and the Surveyor entered Resident #321's room and LPN #6 obtained a blood sample from Resident #321 and checked the resident's blood sample with the glucometer. LPN #6 returned to the medication cart with the glucometer. LPN #6 removed her dirty gloves, performed hand hygiene with hand sanitizer and applied clean gloves. LPN #6 obtained germicidal wipes from the container and cleaned the glucometer. LPN #6 removed her dirty gloves and applied clean gloves. LPN #6 failed to perform hand hygiene after removing her dirty gloves. LPN #6 drew up insulin into a syringe and went back to Resident #321's bedside and administered the insulin to Resident #321. LPN #6 went back to the medication cart, disposed of the insulin syringe and removed her dirty gloves and performed hand hygiene with hand sanitizer. On 11/13/2019 at 4:45 p.m., an interview was conducted with LPN #6. The above observations were reviewed with LPN #6. LPN #6 was asked what should have done after you removed your dirty gloves and before you applied your clean gloves? LPN #6 stated, "I don't know." The Surveyor asked LPN #6, "Should you have performed hand hygiene after removing your dirty gloves and prior to applying the clean gloves?" LPN #6 stated, "Yes." 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.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		

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F 921	Continued From page 103 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to provide a sanitary environment in the kitchen which could potentially affect most of the 35 current residents in the survey sample. The findings included: On 11/13/2019 at 11:30 a.m., while dietary staff were observed preparing lunch trays, under the metal sink which is located next to the steam table and tray line cob webs and dust was observed on the pipes. On 11/13/2019 at 1:05 p.m., the Surveyor observed cob webs and dust on the pipes under the metal sink in the kitchen. The Surveyor asked the Dietary Manager, "What do you see?" The Dietary Manager stated, "I will get someone to clean the pipes." The Dietary Manager was asked if cob webs should be on the pipes under the sink? The Dietary Manager stated, "No, I will get someone to clean the pipes now." The Dietary Manager stated that cleaning the pipes under the sink and counter was not on the cleaning schedule and would have to add it to the schedule. 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.	F 921	1. The cobwebs under the sink were cleared by kitchen staff prior to the survey team exiting the building 2. All residents are at risk when a sanitary environment is not maintained 3. Dietary staff will receive education on cleaning procedures to include locations under the sink. 4. Administrator or designee will perform weekly audits x 8 weeks of the kitchen cleanliness to include areas under the sink. Results of the audits will be shared with the QAPI team and revised as needed. 5. Date of Completion December 27, 2019	

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