STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 2/4/20 through 2/5/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 48 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents #1 through #7).	F 000	Disclaimer Notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident	F 553	F-553 1. Facility failed to invite and afford the opportunity for the resident, family and/or the resident's legal representative to participate in care planning for resident # 1. Care plan meeting for resident #1 scheduled February 20, 2020. Invitation letter sent to responsible party for care plan meeting for resident #1. 2. All residents in the facility have the potential to be impacted in not having a care plan meeting with resident and or responsible party in attendance. 3. A. The facility will conduct a review of care plans for all residents admitted within the past thirty (30) days; confirming that families were invited to care plan meetings. Care plan meetings will be scheduled and invitations sent out for those residents and/or responsible parties noted during audit as not being invited. b. The facility has reviewed its' policies related to "Resident/Family Participation in Care Plans for clarity. No revisions are needed. The Care Plan ITD team was re-educated on the policies concerning "Resident/Family Participation in Care Plans on 2/18/2020.	

RECEIVED
FEB 25 2020
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 2-20-2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 553	Continued From page 1 of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, family interview, staff interviews, and review of the facility's documentation, the facility's staff failed to invite and afford the opportunity for the resident, family and/or the resident's legal representative to participate in care planning for 1 of 7 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 4/1/19, and was discharged from the facility to an acute care hospital, return anticipated on 1/3/20. The resident returned to the facility 1/10/20. The resident's diagnoses included; prostate cancer, dementia, deep vein thrombosis, stroke, and a subarachnoid hemorrhage secondary to a fall. Hospice services were initiated 1/11/20. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. The resident was also coded	F 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 553	Continued From page 2 as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with dressing, eating and personal hygiene, and limited assistance with walking and locomotion. An interview was conducted with Resident #1's daughter and Power-of-Attorney on 2/4/20 at approximately 11:00 a.m. The daughter stated she had received only one invitation to participate in the resident's care planning and that was shortly after admission. Review of the care plan conference record revealed the facility staff held care planning meetings on 4/3/19, 7/18/19, 10/31/19 and 1/23/20. The signatures included Resident #1's daughter's signature on 4/3/19. An interview was conducted with the MDS Coordinator on 2/5/20 at approximately 12:15 p.m. The MDS Coordinator stated the only care plan invitation letters that could be located was dated 9/11/19 but the Social Worker was responsible for ensuring invitations were sent to residents and families. The MDS Coordinator further stated she didn't know who had taken on that role since the Social Worker left approximately two months ago. The MDS Coordinator stated she attends all care planning meetings and she didn't recall Resident #1 or family attending the last few care plan meetings. On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. No additional information was offered.	F 553	4. The MDS coordinator or Social Services Director will audit new admissions to verify letters of invitations have been sent to the resident and/or responsible party weekly x four weeks and monthly x two weeks. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members will be responsible for the ongoing monitoring of this process as follows: 5. Completion Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641 F 641 SS=D	Continued From page 3 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 information obtained during a complaint investigation, family interview, staff interviews, and review of the clinical record, the facility staff failed to accurately code the 1/17/20 Minimum Data Set (MDS) assessment for 1 of 7 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 4/1/19, and was discharged from the facility to an acute care hospital, return anticipated on 1/3/20. The resident returned to the facility 1/10/20. The resident's diagnoses included; prostate cancer, dementia, deep vein thrombosis, stroke, and a subarachnoid hemorrhage secondary to a fall. Hospice services were initiated 1/11/20. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. The resident was also coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with dressing, eating and personal hygiene, and limited assistance with walking and	F 641 F 641	F-641 1. Facility failed to accurately code the 1/17/20 Minimum Data Set (MDS) assessment for resident #1 for prostate cancer, dementia, Deep vein thrombosis, stroke and a subarachnoid hemorrhage. MDS corrected and submission confirmed on 2/17/2020. 2. All residents have the potential for inaccurate assessments. a. The MDS Nurse has reviewed the RAI manual section I for clarity on 2/17/2020. b. An audit will be completed by 2/29/2020 on all residents who were admitted within the last 30 days to verify diagnosis is coded correctly. Corrections will be made and the MDS will be resubmitted. 3. The MDS Nurse will audit the MDS weekly x 4 then monthly thereafter for 2 months on re-admitted residents. 4. Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The MDS Nurse will report variances to the QAA committee. The QAA Coordinator and its members will be responsible for the ongoing monitoring of this process as follows: 5. Completion Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 locomotion. In section "I" new diagnoses identified during the resident's 1/3/20, through 1/10/20 hospitalization were not coded on the 1/17/20, MDS assessment. They were deep vein thrombosis, stroke, and a subarachnoid hemorrhage. An interview was conducted with Resident #1's daughter and Power-of-Attorney on 2/4/20 at approximately 11:00 a.m. The daughter stated she had spoken with the Nurse Practitioner multiple times since the resident had been readmitted to the facility and the Nurse Practitioner explained the new diagnoses of deep vein thrombosis, stroke, and a subarachnoid hemorrhage to her. Review of the hospital discharge summary dated 2/10/20 revealed the following clinical summary: Resident presented from a nursing home following a fall and altered mental status. A small volume left frontal lobe subarachnoid hemorrhage following a fall 1/8/20, a subacute stroke, and a new deep venous thrombosis in the left posterior tibial and peroneal veins. No physician or designee progress notes since Resident #1's readmission to the facility 1/10/20 were available in the clinical record to be viewed and neither were the hospice agency's notes or care plan available in the clinical record to be viewed since the resident was admitted to their service. Hospice services were begun 1/11/20. All requested Physician/Nurse Practitioner and hospice progress notes and the hospice care plan requested had to be faxed from the provider to the facility to be viewed.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 Review of the resident's current list of diagnoses dated 2/1/20 and the care plan with a revision date of 1/28/20, didn't reveal the new diagnoses of deep vein thrombosis, stroke, and a subarachnoid hemorrhage. An interview was conducted with the MDS Coordinator 2/5/20 at approximately 12:15 p.m. The MDS Coordinator stated the new diagnoses were not documented in the clinical record therefore; they were not included on the significant change MDS assessment date 1/17/20. An interview was conducted with the Nurse Practitioner 2/5/20 at approximately 1:30 p.m. The Nurse Practitioner stated the daughter of Resident #1 is updated frequently and the progress notes explains the resident's hospital course and treatment plans and the new diagnoses from the hospitalization. They included deep vein thrombosis, stroke, and a subarachnoid hemorrhage. The Nurse Practitioner stated all progress notes are transmitted to the facility immediately after they are written. The Nurse Practitioner further stated the turn-around time for progress notes is no more than the following day, then the notes are faxed to the facility to a designated fax machine. An interview was conducted with the Director of Nursing (DON) 2/4/20 at approximately 4:35 p.m. The DON stated they orginally thought the Medical Records Clerk had not scanned the documents in the system but further reviewed revealed when the cubix was installed in the nurse's station the fax machine line was disconnected. The DON further stated the fax machine in the nuse's station was the designated	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 fax for physician progress notes as well as notes from the hospice agency On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated the hospital's discharge summary was given to the nursing staff by the transportation personnel at the time of the resident's readmission therefore; the information was included in the clinical record.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, family interview, staff interviews, and review of the clinical record, the facility staff failed to provide adequate supervision to prevent exiting from the nursing facility for 1 of 7 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 4/1/19, and was discharged from the facility to an acute care hospital, return anticipated on 1/3/20. The resident returned to the facility 1/10/20. The resident's diagnoses included prostate cancer,	F 689	F-689 1. Facility staff failed to provide adequate supervision to prevent exiting the facility for resident #1. 2. All residents of the facility have the potential to be impacted in exiting from the facility without adequate supervision by staff. 3. a. Wandering assessments on residents were completed on 2/5/2020 to determine residents at risk for elopement. b. Those residents at risk discussed by IDT team to determine who needs wander guard placed. c. Facility staff educated on monitoring residents frequently that reside in the community. d. Staff to be educated on missing resident procedure. 4. a. MDS coordinator and DON to audit new admissions and residents who have a quarterly at-risk for wandering assessment completed weekly x 4 weeks and monthly x 2 months. b. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members will be responsible for the ongoing monitoring of this process as follows: 5. Completion Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 dementia, deep vein thrombosis, stroke, and a subarachnoid hemorrhage secondary to a fall. Hospice services were initiated 1/11/20. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. The resident was also coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with dressing, eating and personal hygiene, and limited assistance with walking and locomotion. An interview was conducted with Resident #1's daughter and Power-of-Attorney on 2/4/20 at approximately 11:00 a.m. The daughter stated she was notified the resident exited the building 1/14/20, and was located in the staff parking lot at the facility and it was raining and cold. The daughter felt insufficient staff was the reason the resident was able to exit the facility without staff knowledge. Review of the nurse's note dated 1/14/20 at 8:33 a.m., revealed the resident was found outside sitting on the stoop. Review of the facility's nurse staffing revealed on 1/14/20 the 11:00 p.m., through 7:00 a.m., shift was staffed with two Certified Nursing Assistants (CNA) and two Licensed Practical Nurses (LPN). The staffing model for the facility dated 8/18/17 revealed based on the facility's risk assessment	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 two CNAs and two LPNs was sufficient staff to meet each resident's needs. On 2/4/20 at approximately 2:37 a.m., an interview was conducted with CNA #1 who stated Resident #1 was known to sit on the front porch, watch the cars, wave to persons coming and going and hold a short conversation prior to the early January 2020 hospitalization. After the hospitalization CNA #1 stated the resident showed a decline, didn't go outside unassisted anymore and showed a very unsteady gait when walking. On 2/4/20 at approximately 4:20 p.m. an interview was conducted with Registered Nurse (RN) #1. RN #1 stated Resident #1 was more active approximately two month ago. The resident was almost independent with care, ambulated unassisted and without gait concerns, was alert and oriented times 2-3, and frequently went outside to sit on the porch to people/car watch. RN #1 stated after the fall and the recent hospitalization the resident was more dependent on staff and only went outside with family. RN #1 stated the resident had previously received hospice care, which was discontinued but resumed after the January 2020 hospitalization. An interview was conducted with the Director of Nursing (DON) on 2/4/20 at approximately 4:35 p.m., regarding Resident #1 leaving the building at 5:30 a.m., because one nurse was an agency nurse and was unavailable to be interviewed. The other LPN had resigned and the CNA assigned to the resident was no longer was employed by the facility. The DON stated the nurse's note didn't reflect the investigation of the event. The DON stated the investigation revealed at approximately	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 5:30 a.m. on 1/14/20, the alarm system was activated and the staff telephoned her to get instructions on how to deactivate the system. The DON stated she educated the staff to first view the panel located in the nurse's station to reveal which exit had activated the alarm. The panel revealed the exit door on the Bent Hall had been opened. The DON stated the staff was educated to stop the alarm from sounding and the staff was instructed to complete a head count of residents because the alarm had be activated by an individual (resident, visitor or staff). Results of the head count revealed Resident #1 was absent. The staff conducted a search which revealed the resident was outside of the building, sitting in an uncovered area in the staff parking lot. The DON further stated the staff reported the resident was wet and cold. The DON stated the intervention to aid in preventing further episodes of the resident leaving the building unassisted was a wander guard alert bracelet was applied to the resident's body. On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The facility staff was offered the opportunity to provide additional information but they did not.	F 689		
F 842 SS=D	Complaint Deficiency. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 842	Continued From page 10 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. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	F-842 1. Facility staff failed to ensure a complete and accurate record including nurse practitioner progress notes, hospice progress notes and hospice care plan for resident #1. Nurse practitioner notes, hospice notes and car e plan received for resident #1 and uploaded into resident #1 electronic medical record. 2. All resident could be affected in not receiving nurse practitioner notes, hospice notes and hospice care plan. 3. a. Once identified of the disconnected fax line; the line was immediately connected. b. audit to be completed for residents on hospice and seen by nurse practitioner. Nurse practitioner notes, hospice notes and hospice care plans to be obtained and placed in resident's electronic records for residents identified. 4. a. DON or designee to audit resident's receiving hospice care and seen by nurse practitioner weekly x 4 and monthly x 2 to verify progress notes and care plans are received. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members will be responsible for the ongoing monitoring of this process as follows: a) daily monitoring of the fax line for 30 days. b) any variances will be immediately corrected. 5. Complete Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 842	Continued From page 11 §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 information obtained during a complaint investigation, family interview, staff interviews, and review of the clinical record, the facility staff failed to ensure a complete and accurate record for 1 of 7 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 4/1/19, and was discharged from the facility to an acute care hospital, return anticipated on 1/3/20. The resident returned to the facility 1/10/20. The resident's diagnoses included prostate cancer, dementia, deep vein thrombosis, stroke, and a subarachnoid hemorrhage secondary to a fall. Hospice services were initiated 1/11/20.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 842	Continued From page 12 The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. The resident was also coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with dressing, eating and personal hygiene, and limited assistance with walking and locomotion. In section "I" new diagnoses identified during the resident's 1/3/20, through 1/10/20, hospitalization were not coded on the 1/17/20, MDS assessment. They were deep vein thrombosis, stroke, and a subarachnoid hemorrhage. An interview was conducted with Resident #1's daughter and Power-of-Attorney on 2/4/20 at approximately 11:00 a.m. The daughter stated she had spoken with the Nurse Practitioner multiple times since the resident had been readmitted to the facility and the Nurse Practitioner explained the new diagnoses of deep vein thrombosis, stroke, and a subarachnoid hemorrhage to her. Review of the hospital discharge summary dated 2/10/20 revealed the following clinical summary: Resident presented from a nursing home following a fall and altered mental status. A small volume left frontal lobe subarachnoid hemorrhage following a fall 1/8/20, a subacute stroke, and a new deep venous thrombosis in the left posterior tibial and peroneal veins.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 842	Continued From page 13 No physician or designee progress notes since Resident #1's readmission to the facility 1/10/20 were available in the clinical record to be viewed and neither were the hospice agency's notes or care plan available in the clinical record to be viewed since the resident was admitted to their service. Hospice services were begun 1/11/20. All requested physician/Nurse Practitioner and hospice progress notes and the hospice care plan requested had to be faxed from the provider to the facility to be viewed. Review of the resident's current list of diagnoses dated 2/1/20 and the care plan with a revision date of 1/28/20, didn't reveal the new diagnoses of deep vein thrombosis, stroke, and a subarachnoid hemorrhage. An interview was conducted with the MDS Coordinator 2/5/20 at approximately 12:15 p.m. The MDS Coordinator stated the new diagnoses were not documented in the clinical record therefore, they were not included on the significant change MDS assessment date 1/17/20. An interview was conducted with the Nurse Practitioner 2/5/20 at approximately 1:30 p.m. The Nurse Practitioner stated the daughter of Resident #1 is updated frequently and the progress notes explains the resident's hospital course and treatment plans and the new diagnoses from the hospitalization. They included deep vein thrombosis, stroke, and a subarachnoid hemorrhage. The Nurse Practitioner stated all progress notes are transmitted to the facility immediately after they	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 842	Continued From page 14 are written. The Nurse Practitioner further stated the turn-around time for progress notes is no more than the following day, then the notes are faxed to the facility to a designated fax machine. An interview was conducted with the Director of Nursing (DON) 2/4/20 at approximately 4:35 p.m. The DON stated they originally thought the Medical Records Clerk had not scanned the documents in the system but further reviewed revealed when the cubix was installed in the nurse's station the fax machine line was disconnected. The DON further stated the fax machine in the nurse's station was the designated fax for physician progress notes as well as notes from the hospice agency On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated they had maintenance personnel get the fax machine in the nurse's station back in working order but they have designated another fax machine for receiving progress notes thus there will be more accountability.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 15 arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death.	F 849	F-849 1. Facility staff failed to ensure the hospice agency provided the facility staff with the coordinated plan of care and to identify which services the hospice agency would be provided, the communication process, and when or why the nursing facility staff should notify the hospice agency for resident #1. 2. All residents receiving hospice services could be affected in ensuring the hospice agency provided the facility staff with the coordinated plan of care and to identify which services the hospice agency would be provided, the communication process, and when or why the nursing facility staff should notify the hospice agency. 3. Hospice vendors prior to providing services will meet the facility staff including Social Services, DON/ADON and the Nursing staff to review the processes, services being delivered; including hospice's Social Worker, RN's, Certified Nursing Assistants and Chaplin along with the reporting responsibilities including care plan reviews with both resident/families and facility staff. 4. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC"). The QAA Coordinator and its members will be responsible for the ongoing monitoring of this process as follows: a) Identify new residents who will be receiving hospice services. b) Identify the Hospice provider. c) Schedule a meeting with the hospice provider. d) To ensure in reviewing the processes as identified in section number 3. 5. Completion Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 16 (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 17 becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 18 to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, family interview, staff interviews, and review of the clinical record, the facility staff failed to ensure the Hospice Agency provided the facility staff with the coordinated plan of care, for 1 of 7 residents (Resident #1) in the survey sample, to identify which services the Hospice Agency would provide, when the services would be provided, the communication process, and when or why the nursing facility staff	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 19 should notify the Hospice Agency. The findings included: Resident #1 was originally admitted to the facility 4/1/19, and was discharged from the facility to an acute care hospital, return anticipated on 1/3/20. The resident returned to the facility on 1/10/20. The resident's diagnoses included; prostate cancer, dementia, deep vein thrombosis, stroke, and a subarachnoid hemorrhage secondary to a fall. Hospice services were initiated 1/11/20. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. The resident was also coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with dressing, eating and personal hygiene, and limited assistance with walking and locomotion. An interview was conducted with Resident #1's daughter and Power-of-Attorney 2/4/20 at approximately 11:00 a.m. The daughter stated due to Resident #1's decline in the hospital hospice services were elected to be resumed upon return to the nursing facility. Review of the physician order summary revealed an order to admit to hospice dated 1/11/20. Review of the clinical record revealed no notes by	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 20 the hospice agency, no facility notes hospice services were rendered and no hospice care plan. The facility's care plan with a revision date of 1/13/20 read under the problem: My prognosis is poor. I am aware of my condition, experiencing a significant decline in health and would benefit from care and comfort measures provided by hospice services. The goal read: I will accept hospice care and receive specialized end of life, palliative care. Hospice will help me and my family work through the dying process and have a peaceful death with tolerable pain through the next review date 2/5/20. The interventions include; please administer the medications for pain and discomfort that hospice has recommended for me with my Physician/Nurse Practitioner approval. Please meet with hospice to discuss and update my plan of care as my disease progresses. Notify hospice of all significant condition changes that may occur. Work with hospice to ensure my needs are met during this period of my life. An interview was conducted with certified nursing assistant (CNA) #2 on 2/4/20 at approximately 2:49 p.m. CNA #2 stated hospice aides and a nurse visits multiple times weekly but exactly what days and for what time span she was unable to state. CNA #2 stated the aides provides bathing and grooming and assists the resident into the chair but she has never observed anyone from hospice assist the resident with meals or to go outside. An interview was conducted with Registered Nurse (RN) #1 on 2/5/20 at approximately 4:20 p.m. RN #1 stated when the hospice nurse	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 849	Continued From page 21 comes to visit Resident #1, she stops at the nurse's station and interview the nurse caring for the resident. After the interview the nurse visits the resident and sometimes they see her leave but never does the hospice nurse leave the facility's staff a progress note or talk to the assigned nurse prior to leaving the facility. RN #1 stated she thought the hospice aide comes daily but she's not sure. RN #1 stated the hospice aide usually arrives between 9:00 and 11:00 a.m., and stays 15-20 minutes, assisting Resident #1 with bathing grooming, dressing and getting up for the day. RN #1 stated she has never seen the hospice Social Worker or Chaplain and no one had introduced themselves as a member of the hospice agency. RN #1 stated the facility staff provides all care needed regardless if hospice is coming or not and hospice didn't provide instructions when or what to notify hospice agency of regarding Resident #1. On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated the Chaplain had been in today; she knew because she recognized him not because he made himself known but they believe the information would have been in the facility if the fax machine had not been unplugged. The Administrator stated they had maintenance personnel get the fax machine in the nurse's station back in working order but they have designated another fax machine for receiving progress notes thus there will be more accountability.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 §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; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880	F-880 1. Facility failed to implement an infection control program which identifies, reports and control infections and communicable diseases. Residents identified with scabies were treated as ordered. 2. Residents and staff have the potential to be affected. 3. a. DON and MDS Director completed the training for Infection Control Preventionist. MDS Director completed on 11/21/2019 DON completed on 11/24/2019 and are both certified as Infection Control Preventionists. b) A skin audit had been completed on 1/16/20 on residents no additional issues identified c. Infection control policy and procedure around surveillance for Infections reviewed by DON and MDS Coordinator to include identify, report and control infections and communicable diseases. Education will be provided to the DON and MDS by Kim Morton, RN the regional clinical director. 4. DON and/or Designee will audit the weekly skin assessments weekly x 4 weeks and monthly x 2 months. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members will be responsible for the ongoing monitoring. 5. Completion Date: 3/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 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 information obtained during a complaint investigation, staff interviews, and review of clinical records, the facility's staff failed to implement an infection control program which identifies, reports, and control infections and communicable diseases. The findings included; An interview was conducted with Certified Nursing Assistant (CNA) #1 on 2/4/20 at approximately 2:37 p.m. CNA #1 stated	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 inspectors came out about one month ago because a family member of a resident complained about the resident itching and irritation of the legs and chest area. CNA #1 stated the resident's family took the resident out for an outing and then to the local emergency room because of the skin irritation. CNA #1 didn't know what the emergency room diagnosis was. An interview was conducted with CNA #2 on 2/4/20 at approximately 2:49 p.m. CNA #2 stated one resident's family complained their love one was bitten by bedbugs but no one told her they were truthful. CNA #2 stated Resident #3 frequently has scratches and skin irritation to various body parts and they try to keep the nails cut short to prevent the scratching. CNA #2 further stated several other resident were with rashes as well and at least two residents were quarantined until the rashes improved and one was seen at the hospital for treatment. CNA #2 further stated she wasn't officially told if the rashes were related to bedbug bites or something else. An interview was conducted with the Director of Nursing (DON) 2/4/20 at approximately 4:35 p.m. The DON stated six residents presented with rashes, skin irritations and were scratching over approximately a two week period. One of the six clearly had scabies in between the fingers. The other five were diagnosed with scabies by the Nurse Practitioner and treatment was instituted and was effective. The DON stated currently no residents in the facility was presenting with rash or skin irritations. The DON also stated an announcement wasn't made regarding the scabies but the expectation was for the licensed nurses to give the CNA staff report of each	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 residents status and to utilize personal protective equipment when indicated. Another interview was conducted with the DON on 2/5/20 at approximately 4:45 p.m. The DON stated currently the facility doesn't have an Infection Control Preventionist therefore, she and the MDS Coordinator were managing the infection control program but there was no surveillance documentation of any infections including the six resident diagnosed with scabies. During the interview with the DON 2/5/20 at approximately 4:45 p.m., documentation was not available regarding reporting of communicable diseases nor if the use of personal protective equipment was utilized. On 2/5/20 at approximately 5:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The facility's staff was offered the opportunity to provide additional information but they did not. The Surveillance for Infections policy with a revision date of July 2017 read: Infections that will be included in routine surveillance include those with; a. evidence of transmissibility in a healthcare environment; 3d; (e.g. invasive streptococcus group A, acute viral hepatitis, norovirus, scabies and influenza). Under Data Collection and Recording; collect all pertinent data and daily (as indicated) record detailed information about the resident and infection on an individual infection report form. Calculate infection rates using the daily census and interpret surveillance data for trends.	F 880		