PRINTED: 10/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
		495201	B. WING	B. WING		C 10/09/2020	
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		4201 GREEN	RESS, CITY, STATE, ZIP CODE WOOD DRIVE JTH, VA 23701	10.	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BI OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	COVID-19 Focused S on 10/6/20 and contin 10/9/20. The facility w E0024 of 42 CFR Par Long-Term Care Faci INITIAL COMMENTS	VID-19 Focused Surveyand	F	000			
	a complaint investigation 10/6/20 and continuous 10/9/20. Corrections with 42 CFR Part 483 requirements. The fact	tion was conducted onsite nued offsite 10/7/20 through are required for compliance Federal Long Term Care cility was in compliance with nfection control regulations.					
F 656 SS=D	73 at the time of survey were tested resulting COVID-19. A total of tested resulting in 12 COVID-19. There were and 12 staff recoveries time of survey.	4 certified bed facility was ey. A total of 73 residents in 35 confirmed case of 77 staff members were confirmed cases of re 31 resident recoveries es from COVID-19 at the comprehensive Care Plan	F	56			
	§483.21(b) Comprehe §483.21(b)(1) The fac- implement a compreh care plan for each res- resident rights set for §483.10(c)(3), that ind objectives and timefra medical, nursing, and	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and			TITLE		(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KWQY11

Facility ID: VA0217

If continuation sheet Page 1 of 35

STATEMENT OF D	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII	TIDI	I CONOTTUE	OMB	NO. 0938-0391
AND PLAN OF CO	KKECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION		OATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER		495201	B. WING	_			C
	DER OR SUPPLIER	NTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	1	10/09/2020
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE .	(X5) COMPLETION DATE
nee ass des (i) for r phy req (ii) a und provund trea (iii) a reha provund trea (iv) li resid (iv) l	ressment. The comparison the following of the services that a maintain the resident of the following of the services that a maintain the resident of the following of the follow	re to be furnished to attain nt's highest practicable psychosocial well-being as 4, §483.25 or §483.40; and rould otherwise berequired 25 or §483.40 but are not sident's exercise of rights ng the right to refuse 10(c)(6). rvices or specialized the nursing facility will PASARR facility disagrees with the R, it must indicate its t's medical record. the resident and the resident and the resident and the resident and representation of the ed and any referrals to and/or other appropriate ed. The comprehensive care accordance with the n paragraph (c) of this staff failed to follow the new of six Residents in the survey sample.	F	656			

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		7 50125			COIV		
NAME OF PROVIDER OR SUPPLIER	495201	B. WING			10	C //09/2020	
PORTSIDE HEALTH & REHAB CEI			420	REET ADDRESS, CITY, STATE, ZIP CODE 11 GREENWOOD DRIVE RTSMOUTH, VA 23701		709/2020	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
pian of care and obtain physician's order on 9/2. For Resident #6, fact and document food pecare on several occasi of 2020. The findings included; 1. Resident #4 was add 10/29/19 with diagnose not limited to COVID-11 unspecified protein calc #4's most recent MDS assessment was a qual ARD (assessment referencesident #4 was coded impaired in cognitive furossible 15 on the BIMM Mental Status Exam). Review of Resident #4's that she was diagnosed 8/27/20. The following resulting the physician on 9/3/20; was tested for COVID-1 positive. She was transforoplet precautionsHe her Covid positive result detail that she does not symptoms at this time a monitor her. I will send service wo for Resident #4's (physician order summa)	cility staff failed to follow the n laboratory tests per 73/20. cility staff failed to monitor reentage intake per plan of ons in February and March mitted to the facility on es that included but were 9, Type two diabetes, and orie malnutrition. Resident (minimum data set) reerly assessment with an rence date) of 9/7/20. If as being moderately nection scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Brief Interview for section scoring 12 out of S (Br	F	phy from correction of the cor	For Resident #4, the community spoke with the ovider and received orders to obtain missed labor on 09.03.2020. Resident #4 did not experience as feet of the missed laboratory test. For Resident #1 mitted documentation for food percentage could receted as time has passed. A 100% audit was completed on residents who revision ordered laboratory test. No other resident exted by this deficient practice. A 100 % audit was mpleted on monitoring and documenting food per plan of care for residents. No other residents we extend by this deficient practice. Current licensed nurses will be educated on follow of care as it relates to obtaining laboratory test resician orders. Current nursing staff will be educated on for care. MDS Coordinator or designee will monitor residents aduly to ensure interventions are followed. Do ignee will monitor resident records weekly and a nasure food percentage intake is documented per complete and or patterns and/or fre-educated when deficient practice is identified lits reported to QAPI for input and guidance. Be of Compliance: 11.13.2020	resident's ratory test n adverse 6, the not be ecceived ts were vas recentages ere wing the per ated on e per ent care N or is needed plan of		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-0391 ATE SURVEY MPLETED	
		495201	B. WING				С	
PORTSID	PROVIDER OR SUPPLIER E HEALTH & REHAB C			4201	EET ADDRESS, CITY, STATE, ZIP CODE GREENWOOD DRIVE RTSMOUTH, VA 23701	10/09/2020 DE		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	EACTION SHOULD BE TO THE APPROPRIATE		
	D-Dimer (4) one time Completed. Start dat Review of Resident # reveal any evidence completed. There was Resident #4's care planter of the table of table of the table of table of the table of table of the table of table of the table of the table of table	etabolic Panel) (2), PT/INR tional Normalized Ratio (3), e only for 1 day. Status: e: 9/3/20. End date 9/4/20." 44's clinical record failed to that the above test was s no copy of the results in record. an dated 3/19/20 and cumented the following: atbreak, the resident is at elated to) potential virus tt's current health Labs and cultures as 5.m., Resident #4's 9/3/20 was requested from 6.taff Member) #1, the facility m., a telephone interview SM #1, the facility M #2, the DON (Director of I what they could determine atory test for Resident #4; at laboratory test was not not find a requisition form esults in the laboratory M #1 stated, "Lab has no	F	556				

AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495201	B. WING	· 		C	
	PROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIF 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	² CODE	10/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	stated that each indiv specific to their needs updated with any char When asked if it was it to be followed, RN #1 On 10/9/20 at 2:00 p.r were made aware of the #1 stated again that the requisition form for Reference interdisciplinary plan of the followed of the end of the	idual care plan was resident is. RN #1 stated that it is also riges in the resident's status. Important for the care plan stated, "Oh yes." In., ASM #1 and ASM #2 he above concerns. ASM rey did not have a sident #4's labs. Comprehensive Care in part, the following: "An if care will be established staff must be familiar with had all approaches must be was presented prior to exit and Count) -"Your blood is (RBC), white blood cells allood count tests measure and for cells in your blood. This in your overall health. The iagnose diseases and mia, infections, clotting is, and immune system attion was obtained from of Health. Abbolic Panel) - "A CMP is body functions and over and kidney health, and protein levels. Acid and	Fé	656			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-0391 ATE SURVEY OMPLETED
NAME OF F	DDOVIDED OF THE	495201	B. WING				C
	PROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		420	REET ADDRESS, CITY, STATE, ZIP CODE 1 GREENWOOD DRIVE RTSMOUTH, VA 23701		10/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF	(X5) COMPLETION DATE
	metabolic-panel-cmp/ (3) PT/INR (Prothromoratio - "A prothrombin how long it takes for a sample. An INR (internative of calculation be prothrombin is a protest one of several substant (coagulation) factors." obtained from https://medlineplus.googe-test-and-inr-ptinr/. (4) D-Dimer -"A D-dimerblood. D-dimer is a prothat's made when a bloody." This information https://medlineplus.googe-test-and-inr-ptinr/. (4) D-Dimer -"A D-dimerblood. D-dimer is a prothat's made when a bloody." This information https://medlineplus.googe-test-and-inr-ptinr/. 2. For Resident #6, fact and document food percare on several occasion food percare on several occasion food percare on several occasion food googeth food food food food food food food foo	bin/International Normalized of time (PT) test measures clot to form in a blood national normalized ratio) is ased on PT test results. Sin made by the liver. It is inces known as clotting This information was v/lab-tests/prothrombin-tim er test looks for D-dimer in tein fragment (small piece) and clot dissolves in your in was obtained from: v/lab-tests/d-dimer-test/#:~: v/20a%20protein,once%2 ss%20healed. illity staff failed to monitor reentage intake per plan of the per	F	656			

STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(MO) AND STEEL IS A STATE OF			OMB NO. 0938-039		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X	(3) DATE SURVEY COMPLETED		
		495201	B. WING			С		
	PROVIDER OR SUPPLIER DE HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZI 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	P CODE	10/09/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	impaired in cognitive in possible 15 on the Bli Mental Status) exam. Review of Resident #6 note by the Dietitian of the following: "Food at (Percentage) Breakfast Dinner 25 -50 % Food obtained. Weight Proficinches) lying down, W (pounds) Mechanical I meet residents needs. Diet/Supplements as coas needed and monito than) 50 % (percent) of weights and po (by moundesired changes." Review of Resident #6 dated 2/12/20 docume "Resident has increase related to Dx (Diagnosi pressure areas, poor pplace. received mechans secondary to Dx. dysplin nutrition to aid in wormaintenance, tolerate I (with) adequate po inta dietary intake (date initial ternate food if <50 % Review of Resident #6 (Activities of Daily Living several holes (blank spunder meal percentage 2/13/20, 2/15/20, 2/18/2/2/23/20, 2/25/20, 2/27/2/2/23/1/20. All three meals	function scoring 11 out of a MS (Brief Interview for M	F	656				

	AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION		(X3) DA	TE SURVEY		
I				A. BUILDI	TING			MPLETED		
l	NAME OF P	ROVIDER OR SUPPLIER	495201	B. WING	B. WING			C 10/09/2020		
	PORTSID	E HEALTH & REHAB CE			STREET ADDRESS, CITY, STATE, ZIF 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	° CODE		010312020		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC	TION SHOULD BE THE APPROPRIA	TE	(X5) COMPLETION DATE		
	i i f a t i i i i i i i i i i i i i i i i i i	those dates. Review of Resident #6 tracking form revealed following dates under racking form revealed following dates under racking form revealed following dates under racking 3/1/20, 3/5/20, 3/8/20 at through 3/21/20 and 3/21/20 at approximate residence was conducted Nurse) #1, a nurse fam When asked about resistated that nursing state encourage Resident #6 some days he was slow days and that some days and that some days and that some days are of his poor appetent with him. When asked some meals. RN #1 stated that the norgot to chart. RN #1 stated that the norgot to chart. RN #1 stated that he alocumentation is not contact the nurses were also and the system will alert the nurses were also and the roursing aides to ensure that the nursing ai	S's March 2020 ADL I several holes for the meal percentage for Eating: through 3/15/20; 3/18/20 //23/20 through 3/30/20. All documented on the those mately 1 p.m., a telephone ed with RN (Registered miliar with Resident #6. ident #6's appetite, RN #1 if would have to frequently to to eat. RN #1 stated that wer at eating than other ys he would flat out refuse ated that the family was tite and that his intake was a sister would come in and ad what "holes" or blank DL flow sheet for eating, ursing aides must have tated that the nursing ted meal percentage on #1 also stated that back of 2020 meals g documented on a paper timeal percentage was in the computer system to nursing staff if mpleted. RN #1 stated to supposed to go behind ure all documentation /hen asked if she went sto ensure complete and RN #1 stated that MDS	F6	656					

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI		MULTIPLE CONSTRUCTION		OMB NO. 0938-039	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD		ľ	(X3) DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER	495201	B. WING			C	
	E HEALTH & REHAB CE			STREET ADDRESS, CITY, STATE, Z 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	IP CODE	10/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE A	ACTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
	stated that she wasn' nursing aides were not flow sheet. When ask his meal intake if ther spaces on the ADL floshe was aware that Rappetite but there well refusing all three meal Resident #6 would alw stated that the nursing her if Resident #6 refusioned the thow she would have notified the how she would have of an intake of less than not documented on the stated that she was not been made aware verifications to Resident #6 of the care plan, RN # was used as a guide for stated that each individes specific to their needs. Updated with any change when asked if it was into be followed, RN #1 stated that intake should have the control of the care plan that intake should have the control of the care and could not recall that that intake should have the control of the care and could not recall that that intake should have the control of the care and ASM Nursing) were made aware made a	t even aware that the of documenting on the ADL and how she was to monitor the were days of blank of the were days of blank of the were days of blank of the were days of him and the sident #6 had a poor the never days of him and the ways eat something. RN #1 to aides would have alerted used all meals and then she the physician. When asked offered alternate meals for 50 percent; if intake was the clinical record, RN #1 to sure; that she may have the bally by the nursing aide. That far back if any specific offered alternate food to when asked the purpose of the stated that the care plan for resident care. RN #1 that dual care plan was resident RN #1 stated that it is also ges in the resident's status. Inportant for the care plan stated, "Oh yes." When the stated, "Oh yes." When the stated on the ADL that the wasn't sure that far back. RN #1 stated the been documented. "ASM #1, the facility #2, the DON (Director of the care to make the poon of the poon o	F	656			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII	TIRL R. C. C.	OMB N	<u>10. 0938-0391</u>
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		TE SURVEY
NAME OF PROVIDER OR SUPPLIER		495201	B. WING			C 0/09/2020
	E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, 2 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	ZIP CODE	0/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE)	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
t (() () () () () () () () ()	S 483.25 Quality of car Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe practice, the comprehe care plan, and the resion that REQUIREMENT by: Based on staff interview facility documentation of a complaint investigate to provide treatment armanagement of a diable hyperglycemic episode (sugar)* level of over 60 required hospitalization of six residents in the sequence of the facility was review therefore this harm level past non-compliance. The findings included; Resident #6 was admitted with diagnoses that included in surgical aftercare following struction, unspecified malnutrition, diabetes ty difficulty swallowing). Resident with swallowing. Resident was all surgical aftercare following astrointestinal system obstruction, unspecified malnutrition, diabetes ty difficulty swallowing). Resident was all sequences and the sequences of the sequences o	and care provided to and care provided to and care provided to and on the comprehensive ent, the facility must ensure treatment and care in assional standards of ansive person-centered dents' choices. It is not met as evidenced as with a services for the etic resident, that led to a with a blood glucose and on 3/17/20 which a constituting harm for one survey sample, Resident a previously put into place and accepted, and deficiency is cited as a deficiency is cited as a deficiency is cited as a deficient and dysphagia desident #6's most recent and assessment with an anion and accepted to the facility on assessment with an anion and accepted to the facility on assessment with an anion and accepted to the facility on a discharge on an assessment with an anion and accepted to the facility on assessment with an anion and accepted to the facility on a discharge on an assessment with an anion and accepted to the facility on a discharge on an assessment with an anion and accepted to the facility on a discharge on an accepted to the facility of the facility	F	Past noncompliance: no correction required.	plan of	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				OMB NO. 0938-039		
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD			(X3) DATE SURVEY COMPLETED			
		495201	B. WING				С		
	PROVIDER OR SUPPLIER PE HEALTH & REHAB CE			4201	ET ADDRESS, CITY, STATE, ZIP CODE GREENWOOD DRIVE TSMOUTH, VA 23701	1(0/09/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE		
	Resident #6 was code impaired in cognitive in possible 15 on the BII Mental Status) exam. Review of Resident #4 that he was admitted is sliding scale insulin an checks). The following 2/3/20: "Humalog (1): per sliding scale if 151 (subcutaneous-under SQ; 250-299= 9 units subcutaneously before diabetes." This order fd/c'd (discontinued on Assistant (PA). There Resident #6 was place (blood sugar checks) a was discontinued. Further review of Resid MAR (Medication Adm revealed on 2/11/20 (la Resident #6 did not recand 11:30 a.m. The following note was Physician Assistant on 2/11/20 "Following up to including BMP (2), CBC studiesBMP (basic mfor persistently elevated (previously 2.35), BUN 34, potassium 4.8, sodimg/dL Blood glucosemg/dL, averaging in the	ed as being moderately function scoring 11 out of a MS (Brief Interview for 6's clinical record revealed to the facility on 2/3/20 with and Accuchecks (blood sugar gorder was in place on Solution 100 unit/ml Inject 1-199 = 3 units SQ the skin); 200-249 = 6 units SQ; 300-349 = 12 units; a meals and at bedtime for for sliding scale insulin was 2/11/20) by the Physician was no evidence that and on any Accuchecks after his sliding scale insulin dent #6's February 2020 inistration Record) ast day of Accuchecks) quire insulin at 8:00 a.m. Is documented by the 2/16/20 as a late entry for oday regarding repeat labs C (3), liver function etabolic panel) significant dicreatinine (4) of 2.53 (blood urea nitrogen) (5) um 141, glucose 128 is range from 99 to 216 a 150s to 160s most 3CSTAT (immediately)	F	684					

	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	TIDLE COLUMN	OM	B NO. 0938-0391	
	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3)) DATE SURVEY COMPLETED	
	NAME OF B	POVIDED OF THE	495201	B. WING	-		С	
		ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, Z 4201 GREENWOOD DRIVE	ZIP CODE	10/09/2020	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
	to to the state of	Further review of Resi order summary) revea initially ordered on 2/1 2/24/20; "CBC and BM laboratory test was do 2/25/20. Review of Resident #6 dated 2/25/20; reveale glucose level of 317. T signed by the physician after the resident was don 3/17/20. Review of a nursing no documented the following lethargic. Blood Sugar of PA) at facility. Resident PA), order received to signed by the physician after the resident was don 3/17/20. Review of a nursing no documented the following lethargic. Blood Sugar of PA) at facility. Resident PA, order received to signed and the following lethargic and the following lethargic at the patient's relecting over the past signed cations. He sleeps to (by mouth) intake he pook him to a doctors apoticed that he seemed allood glucose was checited the process of the patient of the pook him to a doctors apoticed that he seemed allood glucose was checited the patient of the patient of the pook him to a doctors apoticed that he seemed allood glucose was checited the patient of the pati	ident #6's POS (physician alled the following lab orders 7/20; with a start date of 1/12" one time only." This cumented as completed on 1/2" laboratory test (BMP) desident #6 had a blood this laboratory test was not in until 4/2/20 which was discharged to the hospital 1/2" laboratory test was not in until 4/2/20 which was discharged to the hospital 1/2" laboratory test was not in until 4/2/20 which was discharged to the hospital 1/2" laboratory test was not in until 4/2/20 which was discharged to the hospital 1/2" laboratory test was not in until 4/2/20 which was discharged to the hospital 1/2" laboratory test was not in until 4/2/20 which was check, result HI. (Name of it evaluated by (F	DEFICIE 684	OTHE APPROPRIATE INCY)	DATE	
	п	e nas a diagnosis of di	et controlled type II 4 % February 2020. Most					
p	ACMS SECTION	00) 5					T 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORPECTION (X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	OMB N	OMB NO. 0938-039			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		495201	B. WING)		С
	PROVIDER OR SUPPLIER DE HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	11	10/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
F 684	recent spot blood gluck three weeks ago was having his blood gluck he had remained well-taking any medication performed 2/25 includ online today and revie for elevated creatinine 1.65 on 2/25 result), B 2/25 result), potassium 317 mg/dL. It does not were made aware of the elevated glucose was the lab results were not on examination today, in an obtunded state. So noted on his breath. Unwith sternal rub or vertachycardic at 103 bpm change in mentation, or greater than 600 mg/dl is being sent via 911 to now" Review of Resident #6' plan for Diabetes documed a plan for Diabetes docum	cose check was performed 130 mg/dL. He was not use checked regularly since controlled and was not use checked regularly since controlled and was not use checked regularly since controlled and was not use checked used. This was significant used to find the control of the	F	684		

STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(VO) HILL TIPL T			OMB NO. 0938-039		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED	
		495201	B. WING		1	С	
NAME OF F	PROVIDER OR SUPPLIER			CTDEET ADDRESS		10/09/2020	
PORTSID	E HEALTH & REHAB CE	*		STREET ADDRESS, CITY, STATE, ZIP COL	DE		
	- WENTER OF	ENTER	1	4201 GREENWOOD DRIVE			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		PORTSMOUTH, VA 23701			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 3 E S E S L	Diabetes Association sliding scale insulin w Accuchecks should coregularly. Repeat BMI Review of Resident #4 conducted. The Histor 3/17/20 documented the from nursing home for hyperglycemia. Hyperestate, Altered mental sthe above; Acute on clailure; likely secondar Leukocytosis (elevated be secondary to the ability of the best of the secondary to the ability of the best of the secondary to the ability of the best of the secondary to the ability of the secondary to the secondary to the ability of the secondary to the secondary to the ability of the secondary to the secondary to the ability of the secondary to the secondary to the s) guidelines). Therefore, fill be discontinued but ontinue to be monitored P scheduled for 2/16/20." 6's hospital records was ry and Physical dated the following: "brought altered mental status and osmolar Hyperglycemic (8) status; likely secondary to thronic Stage IV (four) renal ry to the above, diwhite blood cells); could cove; rule out sepsis bught from nursing home tess responsive. Blood the limitIn the ED his cove 1100 and with the received IV (intravenous) is an agement3/17/20 at the second status and is nagement3/17/20 at the second status in	F 68				

ND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MI II	TIDLE	DONO-TO-	OMB N	IO. 0938-0391
IND FLAIN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		TE SURVEY
			A. BOILD	ING		COMPLETED	
		495201	B. WING				
AME OF P	PROVIDER OR SUPPLIER		D. WING			1 10	0/09/2020
					REET ADDRESS, CITY, STATE, ZIP CODE		
OKISID	E HEALTH & REHAB CE	NTER			1 GREENWOOD DRIVE		
(X4) ID	010000			PO	RTSMOUTH, VA 23701		
PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD	RE	(X5) COMPLETION
		,	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				-	DEFICIENCY)		
F 684	minada i form page	14	Г.	20.4			
	SSI (sliding scale insu	ılin) because his blood	F 6	004			
	sugar had been stable	and his HA1c was within					
	normal limits on his la	st drawn laboratory test					
	prior to 2/11/20, ASM :	#4 stated, "If you look at the					
	ADA guidelines, there	was no indication for					
	Accuchecks and SSL	sliding scale insulin)." ASM					
	#4 stated that she usu	ally writes an order to					
	continue blood sugar of	checks for a few weeks					
1	after sliding scale insul	lin is discontinued for her	1				
	diabetic residents ASM	M #4 stated that staff did					
	not continue to monitor	his blood sugar levels; but					
	that it was not indicated	d ner ADA quidolines					
	When asked how ASM	#4 conveys orders to the					
	nursing staff, ASM #4 s	stated that most after					
1	time, she will discontinu	re and input orders directly				1	
l i	into the computer syste	em herself. ASM #4 stated,					
	"I find that doing it myse	elf is necessary." When					1
1	asked if she could reco	Il inputting Resident #6's					
	orders to d/c (discontinu	in inputting Resident #6's					
i	f she have the order to	ue) sliding scale insulin or					
i i	hat she could not rocal	the nurse; ASM #4 stated I. ASM #4 stated that it					1
v	Was her intention to how	/e nursing staff monitor					
F	Resident #6's blood sug	re lovels of a line				1	
s	scale insulin was discor	gar levels after sliding					
S	stated that nursing stoff	oles falls III				- 1	
a	Providers aware of a ori	also failed to make any					
2	2/25/20 BMP test. ASM	tical glucose level on his					
е	elevated diucose was a	#4 stated that the					1
v	/as actually at 217\ Ac	a level of 329 (sic; sugar					- 1
h.	was actually at 317). ASM #4 stated that if she had seen that elevated blood sugar, she would have ordered additional monitoring at that time.						1
h							1
l v							
When asked if the failure to continue blood sugar checks and the failure to report a critical lab caused Resident #6 harm; ASM #4 stated that							
ek	de coniquit com thet is	ii, ASM #4 stated that					
D.	ne couldn't say; that if s	one nad monitored					1
Dr.	COLUCIII #0 & DIOOG SUG	BIS after the critical lab it		1		14.0	- 1
Resident #6's blood sugars after the critical lab it probably would have been for a week or two		II dai ino orido orid		1			
pi	obably would have bee	en for a week or two					
ar	nobably would have bea nyway. When asked if s	en for a week or two she could have possibly adings and orderedsome					

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	OMB N	OMB NO. 0938-0391		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED	
		495201	B. WING		1	С	
NAME OF	PROVIDER OR SUPPLIER			CTDEET ADDRESS	1(0/09/2020	
PORTSI	DE HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP (CODE		
	THE MENT OF REMARK CE	NIER		4201 GREENWOOD DRIVE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PORTSMOUTH, VA 23701			
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	sort of medication/trea of his type two diabete couldn't say; that she was blood sugars being ele #6 was discharged to did not access to his his stated that Resident #infection; that she recaphysician saying his Sinfected. Review of Resident #6 and hospital records fainfected wounds. On 10/8/20 at approxint telephone interview was (Registered Nurse) #1. for obtaining ordered lastated that once the philaboratory test, nursing requisition form and pur #1 stated that laborator early morning on 11-7 stechnician. RN #1 state technician will check the blood to determine which work. RN #1 stated that obtained, the nurse will MAR/TAR (Medication A) Treatment Administration completed. When asked follow up on a laboratory drawn, RN #1 stated that information in report, and up on the lab. RN #1 stated that information in report, and up on the lab and can all stated that lab and can all stated the lab book to sect a support the lab and can all stated the lab and	atment for the management as, ASM #4 stated that she wasn't sure the cause of his evated because Resident the hospital on 3/17/20 and ospital records. ASM #4 and may have had an alled the wound care tage 4 sacral ulcer was as a sacral ulcer was as a sacral ulcer was a sacral ulc	F 6				

AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII		0	MB NO.	0938-03	
	OF CORRECTION	IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				X3) DATE S COMPL	URVEY	
NAME OF		495201	B. WING			С		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/0	9/2020	
PORTSID	E HEALTH & REHAB CE	ENTER	- 1	4201 GREENWOOD DRIVE	DE			
(X4) ID	SUMMARY	TATELIE		PORTSMOUTH, VA 23701				
PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE		(X5) COMPLETION DATE	
th the state of th	would immediately call stated that from there orders; the nurses the communication book of the when asked if nurses laboratory test was observiewed; or if the physical personally will also do asked if the laboratory the electronic medical were reviewed by the part of the electronic medical were reviewed by the part of the electronic medical were reviewed by the part of the electronic medical were reviewed by the part of the electronic medical were reviewed by the part of the electronic medical were reviewed by the part of the electronic medical the for scanning in lab results that are scanne ecord have to be signer of the electronic medical discovers with the electronic medical discovers. As were separate or esident #6's Accuchected with the electronic medical ensulin Accustomatical electronic mediately and address as her mistake however well should have been remediately and address the determined that facility.	usually faxed to the nursing eive an abnormal lab, they an abnormal lab, they are the physician. RN #1, the physician would give an file the lab into a for the MD (Medical Doctor), should document that the tained and results were sician was made aware of a RN #1 stated, "Me, a nurse's note." When results were scanned into record once the results obysician, RN #1 stated ber usually scanned the computer system. RN staff member responsible alts. RN #1 stated that the did into the electronic health and by the physician first. In further interview was a the PA. ASM #4 stated antinuing the insulin order that she forgot to write an disugar checks. ASM #4 stated that the did sugar checks. ASM #4 stated that the did sugar checks and sliding scale ders. ASM #4 stated that the did suchecks were also atted that she assumed atted order for Accuchecks SM #4 stated that that in the critical glucose enorted to the providers.	F 6					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495201 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSIDE HEALTH & REHAB CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM	OMB NO. 0938-039	1
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM	(X3) DATE SURVEY COMPLETED	•
PORTSIDE HEALTH & REHAB CENTER (X4) ID PREFIX TAG F 684 Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM	С	
F 684 Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM	10/09/2020 DE	
F 684 Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM	SHOULD BE COMPLETION	
#4 went back to Resident #6's chart to look at recent labs and noticed the lab that was ordered for 2/25/20 was not in his clinical record. ASM #4 then stated that she had to look up the lab in the laboratory system and found the elevated glucose level. ASM #4 then stated that she went back to Resident #6's clinical record to see what his Accuchecks had been running and realized that no one was monitoring his blood sugar levels after the insulin was discontinued. On 10/8/20 at approximately 5:00 p.m., ASM (Administrative Staff Member) #1, the Administrativa and ASM #2, the DON (Director of Nursing) were made aware of the potential for harm. Any additional information was requested at this time. On 10/9/20 at approximately at 1:17 p.m., ASM #1 and ASM #3, the corporate nurse provided a plan of correction that had been started in response to Resident #6's hyperglycemic episode. The following was documented: "1. On 3/17/20, resident, (Name of Resident #6) was sent out by ambulance to the hospital for a high blood sugar. The physician's assistant was in the facility and assessed him and sent him to the ER. The responsible party for the resident was notified. 2. The facility conducted a 100 percent audit of current residents with a diagnosis of Diabetes to identify others who may not have had their blood sugars checked or who did not have a clear order		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB I	OMB NO. 0938-039		
	201101	IDENTIFICATION NUMBER:	A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDED OF THE	495201	B. WING				С
	PROVIDER OR SUPPLIER DE HEALTH & REHAB (CENTER		4201 G	T ADDRESS, CITY, STATE, ZIP CODE REENWOOD DRIVE	1	0/09/2020
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		PORTS	SMOUTH, VA 23701		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	c	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE	(X5) COMPLET DATE	
5 Recompleted and the state of	for blood sugar check facility provided educe (Medical Director), Nothe PA (Physician's aclarifying when blood Completed via phone blood sugars monitor 4/1/20. 3. Education was promursing staff by the Dand RDCS (Regional Services) on Diabete and follow through. Be will also be provided to orientation. 4. Audit daily (M-F) of diagnosis of Diabetes protocol has been ord DON x 3 months. Aud which may require blood ensure that blood gluctorrectly by DON or described that the above applemented by facility and reporting abnormal hysician or provider of 2/2/20. accility Policy titled, "Die provider and staff the prov	cks. Completed 3/31/20. The cation to the physician IP (Nurse Practitioner), and Assistant) on ordering and disugars are to be checked. e 4/2/20. Standing orders for ring was put into place. Evided for the licensed DON (Director of Nursing) Director of Clinical s, Blood Glucose monitoring egan 4/1/20. The education to new hires during I new admissions with a to ensure blood glucose ered and is correct by the it daily (M-F) of new orders od glucose monitoring to sose was scheduled esignee x 3 months. Budits and education e plan of correction was a staff. Further review of the t staff were also educated laboratory tests to the n 3/28/20, 3/31/20, and Babetic Protocol" Following: Will work together to give not to manage diabetes.	F	884			

MAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER (CA) ID SUMMARY STATEMENT OF DEFICIENCES (EACH) DEFICIENCES (EACH) DEFICIENCY (EACH) DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 19 the nurse shall assess/document and report the following: -Any signs and symptoms of infection (urine, skin/wound, upper respiratory etc.) or other acute illinesses; -Change in intake/thirst; -Neurological changes such as changes in level of consciousness or orientation; - Resident's age and gender; -Resident's age and gender; -Resident's age and time of most recent hyperglyemic agent given; -Recent labs Based on the preceding assessment, including cause and complications, the provider may order further interventions, which may include: treatment of underlying conditions causing impaired glucose tolerance; Diet and lifestyle modifications where feasible and accepted by the resident; Oral hypoglycemic agents analor for interventions with a significant blood glucose level changes and deterioration of previous glucose control and document resident's status at subsequent visits until the acute sluation is resolved. g, the provider will follow up on any acute episodes associated with a significant blood glucose level changes and deterioration of previous glucose control and document resident's status at subsequent visits until the acute sluation is resolved. g, the provider will order desired parameters for monitoring and reporting information related to diabetes and blood sugar management. The staff will incorporate such parameters into the Medication Administration Report and care	ND PLAN OF	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY		
ANALO F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 22701 (EACH DEPTICENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 19the nurse shall assess/document and report the following: -Any signs and symptoms of infection (urine, skin/wound, upper respiratory etc.) or other acute lilinesses; -Change in intake/thirst; -Neurological changes such as changes in level of consciousness or orientation; -Resident's age and gender; -Resident's age and gender; -Resident's age and gender; -Resent labsBased on the preceding assessment, including cause and complications, the provider may order further interventions, which may include: treatment of underlying conditions causing impaired glucose tolerance; Diet and lifestyle modifications where feasible and accepted by the resident; Oral hypoglycemic agents and/or -Interventions and complement blood glucose level changes and deterioration of provider will order desired parameters for monitoring and reporting information related to diabetes and blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care			405204				COI			
PORTSIDE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATION OR ISC IDENTIFYING INFORMATION) FREGULATION OR ISC IDENTIFYING INFORMATION FREGULATION OR INFORMATION FREGULATION O	NAME OF PI	ROVIDER OR SUPPLIER	495201	B. WING			1			
F 684 Continued From page 19the nurse shall assess/document and report the following: -Any signs and symptoms of infection (urine, skin/wound, upper respiratory etc.) or other acute illnesses; -Change in intake/thirst; -Neurological changes such as changes in level of consciousness or orientation; - Resident's age and gender; -Resident's age and gender; -Resident's blood sugar history over 48 hours; -Usual patterns (fluctuations, trends) of blood sugars over recent months; -Approximate intake over 24 hours; -Current medications; - Based on the preceding assessment, including cause and complications, which may include: treatment of underlying conditions causing impaired glucose tolerance; Diet and lifestyle modifications where feasible and accepted by the resident; Oral hypoglycemic agents and/or f. The provider will follow up on any acute episodes associated with a significant blood glucose level changes and deterioration of previous glucose control and document resident's status at subsequent visits until the acute situation is resolved. g. the provider will order desired parameters for monitoring and reporting information related to diabetes and blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care					420	1 GREENWOOD DRIVE		010912020		
the nurse shall assess/document and report the following: -Any signs and symptoms of infection (urine, skin/wound, upper respiratory etc.) or other acute illnesses; -Change in intake/thirst; -Neurological changes such as changes in level of consciousness or orientation; - Resident's age and gender; - Resident's age and gender; - Resident's blood sugar history over 48 hours Usual patterms (fluctuations, trends) of blood sugars over recent months; - Approximate intake over 24 hours; - Current medications; - Dose and time of most recent hyperglyemic agent given; - Recent labs Based on the preceding assessment, including cause and complications, the provider may order further interventions, which may include: treatment of underlying conditions causing impaired glucose tolerance; Diet and lifestyle modifications where feasible and accepted by the resident; Oral hypoglycemic agents and/or 1. The provider will follow up on any acute episodes associated with a significant blood glucose level changes and deterioration of previous glucose control and document resident's status at subsequent visits until the acute situation is resolved. 9. the provider will order desired parameters for monitoring and reporting information related to diabetes and blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care	PREFIX	(EVOU DELICIEN	CY MUST BE DDECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	Dec	(X5) COMPLETION DATE		
plan. " Complaint deficiency.	all dia will Me pla	the nurse shall ass following: -Any signs and symp skin/wound, upper regillnesses; -Change in intake/thi-Neurological change of consciousness or Resident's age and Resident's blood sugars over recent material patterns (fluct sugars over re	cotoms of infection (urine, espiratory etc.) or other acute irst; es such as changes in level orientation; gender; gar history over 48 hours. uations, trends) of blood tonths; over 24 hours; est recent hyperglyemic eding assessment, including ons, the provider may order which may include: ag conditions causing rance; Diet and lifestyle easible and accepted by the cemic agents and/or ow up on any acute with a significant blood and deterioration of rol and document resident's risits until the acute are desired parameters for any information related to gar management. The staff	F	384					

Ì	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(70) 1411 =		OMB N	NO. 0938-039
I	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY
I				A. BUILDIN	G	CO	MPLETED
I			495201	P MAINO			С
İ	NAME OF P	PROVIDER OR SUPPLIER		B. WING		1	0/09/2020
ı				1	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ı	PORTSID	E HEALTH & REHAB CE	NTER	1	4201 GREENWOOD DRIVE		
ŀ	(X4) ID	010000			PORTSMOUTH, VA 23701		
ı	PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF COI	PRECTION	
	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	F 684	Continued From page	20				
		*Blood Glucose- "The		F 68	4		
		("sugar", measured in	ma/dl \ in your blood				
		changes throughout th	ne day and night. Your		1		
		levels will change depe	ending upon when what	1			
		and now much you ha	ve eaten, and whether or				
		not you have exercised	d. Normal Blood Sugars				
		normal fasting (no food	for eight hours) blood				
		sugar level is between	70 and 99 mg/dl A				
	normal blood sugar level two hours after eatin less than 140 mg/dL. Diabetes is diagnosed by		el two hours after eating is				
			Diabetes is diagnosed by				
		any one of the following: Two consecutive fasting blood glucose tests that are equal to or greater than 126 mg/dL. Any random blood glucose that is greater than 200 mg/dL. An A1c test that is					
		equal to or greater than	1 6.5 percent. A1c is an				
		easy blood test that giv	es a three month average				
		oi biood sugars. A two-	hour oral alucose	W			
	1	tolerance test with any	value over 200 mg/dl "				1
	1	inis information was of	otained from				1
		https://www.virginiamasc	on.org/whatarenormalblo				
	(odglucoselevels.					
		(1) Humalog- rapid actir	ng insulin used to lower				
	l l	plood sugar. This inform	nation was obtained from				
	7	The National Institutes	of Health				
		nttps://dailymed.nlm.nih.	.gov/dailymed/druglnfo.cf				1
	l n	n/setid=ce8354f4-bf07-4	1923-8755-47f3163662e				1
	4	1				1	1
	1	2) RMD (Pasis **-4. + +	5 B				
	(,	2) BMP (Basic Metabol	ic Panel) - "A BMP is				
	n	ised to check several be	Day functions and				1
	ir	in the body. A	A BMP gives your doctor				1
	h h	OW Much nitronen is in	urea nitrogen (BUN), or your blood to measure				1
	k	idney function, creatining	ne, another indicator of				1
	k	idney function, alucose	or blood sugar(having				
	h	igh or low blood sugar	Could both indicate			l.	
	p	ancreatic issues), carbo	on dioxide (CO2) or				
	bi	icarbonate, a gas that c	an indicate issues with				
٨		2-99) Previous Versions Obsolete					
			Event ID: KWQY11	Feet	h. ID. 144004=		

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	TIDLE GOVERNMENT	OME	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)		
NAME OF ST		495201	B. WING	B. WING		С	
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZID CODE	10/09/2020	
PORTSIDE	HEALTH & REHAB C	ENTER		4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	ZIF CODE		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID				
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE, CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
y b b s p oo irr oo h (3 cc (V th he te cc pr dis Th htt (4) mu not the can in u not Thi http (5) is w can amoinfo http	cometimes not included to tassium, minerals in verall fluid balance, adicates fluid balance, and platelets. The properties of the conditions and also help to additions such as an ablems, blood cancers, and conditions such as an ablems, blood cancers, and fluid flu	s, calcium, which can indicate oid issues (though ded in a BMP), sodium and that indicates your body 's chloride, an electrolyte that e." This information was ational Institutes of Health. e.com/health/cmp-vs-bmp. lood Count) -"Your blood dlls (RBC), white blood cells Blood count tests measure of cells in your blood. This in your overall health. The diagnose diseases and emia, infections, clotting ers, and immune system nation was obtained from so of Health. In the blood count tests.html. ste product made by your ular, everyday activity. If the body in your urine. If a your kidneys, creatinine and and less will be released to urine creatinine levels are sign of kidney disease." but and less will be released to urine creatinine levels are sign of kidney disease." but and less will be released to urine the blood. This exist down. A test the kidney function by the in the blood." This exist from fencylarticle/003474.htm.	F				

AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIJI TIDI	E COMPTE LETTER	OMB N	O. 0938-0391
	- OUNTECHON	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
NAME OF F	PROVIDER OR SUPPLIER	495201	B. WING			С
	E HEALTH & REHAB CE	NTER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE	10	0/09/2020
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ORTSMOUTH, VA 23701		
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	- AOLII D DE	(X5) COMPLETION DATE
(i)	the past two to three in levels, the greater you diabetes complications with diabetes is an HA HA1c test results are in The higher the percent sugar levels over the percent sugar levels are composed to the percent sugar levels are very the percent syndrom. It is a sugar levels are very time. Symptoms of History, the percent urination, and confusion. HHS is a formation was obtained thes://my.clevelandclinic/r-hyperosmolar-hyperg	"The test results give you age blood sugar level over nonths. The higher the risk of developing so the goal for most adults and the provided as a percentage age, the higher your blood ast two to three months." btained from rg/a1c. Ideals that build up when a fat for energy. The most the sin diabetics is insuling ugh insulin, glucose builds and can't enter cells. The ad of glucose." This ad from fat for a long period and the second of the second	F 684			

	STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039		
	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			TE SURVEY MPLETED		
ŀ	NAME OF B		495201	B. WING					
		(EACH DEFICIENCY	NTER ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROPR	V	(X5) COMPLETION DATE		
	SS=D	secondary structural of information was obtain Institutes of Health. https://www.ncbi.nlm.r. Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) (a) Laboratory §483.50(a) (b) The faciliaboratory services to residents. The facility is and timeliness of the services, the services requirements for laboratory services of this chapter. This REQUIREMENT is by: Based on staff interviewand facility document residents, Resident #4, The findings included; Resident #4 was admitted to COVID-19 with diagnoses to timited to COVID-19 inspecified protein calorates and resident #4 was a quant RD (assessment references).	lamage to the brain." This ned from The National hith.gov/books/NBK20383/. Services. lity must provide or obtain meet the needs of its responsible for the quality ervices. Is its own laboratory must meet the applicable atories specified in part 493 is not met as evidenced w, clinical record review eview, it was determined to obtain a laboratory test is order for one of six in the survey sample. Type two diabetes, and rie malnutrition. Resident minimum data set) terly assessment with an ence date) of 9/7/20. as being moderately ction scoring 12 out of		F 770 Laboratory Services 1. For Resident #4, the community spoke with the provider and received orders to obtain missed laboratom of the missed laboratory test. 2. A 100% audit was completed on residents who aphysician ordered laboratory test. No other resident affected by this deficient practice. 3. Current licensed nurses will be educated on following plan of care as it relates to obtaining laboratory test obtained orders. 4. DON or designee will monitor resident records wind as needed to ensure physician ordered laboratory test of the plan of care as it relates to obtained the reviewed for pattern rends, staff re-educated when deficient practice is and results reported to QAPI for input and guidance obtained. Variances: 11.13.2020	received atts were believed the per weekly ry tests and/or			

ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIDLE CONCEDUCTION	OMB NO. 0938-0
: SAM	SI SORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF I	PROVIDER OR SUPPLIER	495201	B. WING		C
	DE HEALTH & REHAB C	ENTER	•	STREET ADDRESS, CITY, STATE, ZI 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	10/09/2020 P CODE
(X4) ID PREFIX TAG	(CACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O	CTION SHOULD BE COMPLETION DATE
F r e e s o C la A A	Review of Resident #4 that she was diagnose 8/27/20. The following the physician on 9/3/2 was tested for COVID positive. She was trained from the physician or positive resident that she does not symptoms at this time monitor her. I will send that she does not symptoms at this time monitor her. I will send the physician order summare following order: "CBC, CMP (Complete Metal (Prothrombin/International Department of the physician order summare following order: "CBC, CMP (Complete Metal (Prothrombin/International Department of the physician order summare following order: "CBC, CMP (Complete Metal (Prothrombin/International Department of the physician order summare following order: "CBC, CMP (Complete Metal Capacity of the physician order of the physi	#4's clinical record revealed sed with COVID-19 on g note was documented by 20: "(Name of Resident #4) D-19 on 8/27/20 -she was nsfer to Covid unit on all Her sister is worried about sults. I discussed with her not have any severe and we will continue to d some blood work today" 4's September 2020 POS mary) documented the (Complete Blood Count) (1) abolic Panel) (2) , PT/INR onal Normalized Ratio (3) , only for 1 day. Status: 9/3/20. End date 9/4/20." 4's clinical record failed to sat the above test was no copy of the results in ecord. In dated 3/19/20 and sumented the following: oreak, the resident is at ated to) potential virus is current health abs and cultures as	F	770	CY)

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) \$44.11 TIPL T		OMB N	O. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495201	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	10	/09/2020
PORTSID	E HEALTH & REHAB CE	NTER		01 GREENWOOD DRIVE		
				DRTSMOUTH, VA 23701		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID			
TAG	REGULATORY OR I	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE
F 770	Continued From page	25				
	did not have laborator 9/3/20.	y results for Resident #4 on	F 770			
i i i i i i i i i i i i i i i i i i i	stated that once the pilaboratory test, nursing requisition form and pulaboratory test, nursing requisition form and pulaboratory test, nursing requisition form and pulaboratory test technician. RN #1 state technician will check the blood to determine whi work. RN # stated that obtained, the nurse will MAR/TAR (Medication Treatment Administration completed. When askefollow up on a laboratory drawn, RN #1 stated the information in report, arup on the lab. RN #1 stated the lab and can accomputer system for the aboratory tests were us station. RN#1 that if the ab; they would immedia the lab into a communication medical Doctor). When document that the laboratory tests were document that the laboratory tests were used the lab into a communication.	as conducted with RN . When asked the process aboratory tests, RN #1 hysician orders the y will create lab slips or a at it into the lab book. RN ry tests are drawn in the shift by the laboratory ed that the laboratory e lab book prior to drawing ch residents need lab once the lab tests is document on the Administration Record or on Record) that it was d how nurses know to y test that was recently at nurses should get the ad then they would follow ated that the nurses can be if the technician had also check the laboratory a result. RN #1 stated that aually faxed to the nursing y receive an abnormal tely call the physician. RN at the physician would at that the nurses then file ation book for the MD asked if nurses should atory test was obtained act; or if the physician was mal lab result, RN #1 vill also do a purse's				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	00110	OMB N	O. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495201	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	16	0/09/2020
PORTSID	E HEALTH & REHAB CE	NTER	420	DI GREENWOOD DRIVE PRTSMOUTH, VA 23701		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID			
TAG	REGULATORY OR I	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDRE	(X5) COMPLETION DATE
F 770	Continued From page	26				
; ;	scanned into the elect the results were review stated that another scanning in lab research that are scanner record have to be sign. On 10/8/20 at 3:12 p.m was conducted with AS Administrator and ASM Nursing). When asked about the 9/3/20 labora ASM #1 stated that that done; that they could n for the lab or find the recomputer system. ASM record." When asked wompleted, ASM #2 staplaced out to the nurse Nurse-LPN #2) who done.	ronic medical record once wed by the physician, RN #1 aff member usually scanned the computer system. RN staff member responsible ults. RN #1 stated that the ed into the electronic health ed by the physician first. In, a telephone interview of the distriction of what they could determine atory test for Resident #4; at laboratory test was not out find a requisition form esults in the laboratory at 1 stated, "Lab has now they they had a call (Licensed Practical cumented that the appleted. This writer also	F 770			
ti ti d tt n tr s b U ui	lue to her COVID positing that nursing staff assignment allowed to access the nurses station. LPN aw the order for the CB e drawn on Resident #-Init 2 nursing station and the make lab slips for the LPN #2 could not reliable.	the nurse who signed completed. LPN #2 stated the COVID hall on 9/3/20 ve status. LPN #2 stated ed to the COVID hall are e rest of the building or #2 stated that when she iC, CMP, D-Dimer etc. to 4; she called over to the d asked the nurse on the				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MUU TU	OLE COMPANY	OMB N	O. 0938-039 [.]
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY 1PLETED
		495201	B. WING			С
	PROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	10	0/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE .	(X5) COMPLETION DATE
(((t	last. LPN #2 stated the stay on the COVID has a requisition form had technician had signed was going to draw Resulp #2 stated that the usually arrives early in the day after the lab is that she documented locompleted because or notified the nurse at the lab slips. LPN #2 state lab as completed, the lab slips. LPN #2 state lab as completed, the lab slips. LPN #2 state lab as completed, the lab slips. LPN #2 state lab as completed from the following that the requisition form for Resinformation was present stated that the facility dobtaining labs. ASM #1 policy regarding following labs. ASM #1 policy regarding following transcribe as orders in order to effect the full transcribe as orders in order to effect the full CBC (Complete Blocomtains red blood cells WBC), and platelets. Be he number and types of the state of the contains red blood cells was a requirement of the state of the state of the contains red blood cells was a requirement of the state of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was a requirement of the contains red blood cells was	vilabs on the COVID side at because she can only allway; she could not check if been created or if the lab off in the lab book that she sident #4's labs on 9/4/20. It laboratory technician the morning to draw labs, ordered. LPN #2 stated Resident #4's labs as ace she saw the order, she is nursing station to create did that if she didn't mark the lab could have possibly resident #4. In, ASM #1 and ASM #2 he above concerns. ASM he did not have a sident #4's labs. No further noted prior to exit. ASM #1 lid not have a policy on was able to present a nog physician's orders. In your overall physician's their implementation ." In your blood (RBC), white blood cells lood count tests measure ficels in your blood. This your overall health. The lagnose diseases and	F 77			

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MUU TIE	215 001105	OMB N	10. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		495201	B. WING			С
1	PROVIDER OR SUPPLIER DE HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE	1	0/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	problems, blood cance disorders." This inform The National Institutes https://medlineplus.go (2) CMP (Complete Mused to check several processes, including: I Blood sugar levels, Blobase balance, Fluid ar Metabolism." This info https://medlineplus.gov/metabolic-panel-cmp/. (3) PT/INR (Prothrombin Ratio - "A prothrombin how long it takes for a sample. An INR (internatype of calculation be Prothrombin is a proteione of several substance (coagulation) factors." obtained from https://medlineplus.gove-test-and-inr-ptinr/. (4) D-Dimer -"A D-dimer blood. D-dimer is a proteinative made when a blobody." This information	ers, and immune system nation was obtained from s of Health. w/bloodcounttests.html. etabolic Panel) - "A CMP is body functions and Liver and kidney health, od protein levels, Acid and not electrolyte balance, rmation was obtained from flab-tests/comprehensive- sin/International Normalized time (PT) test measures clot to form in a blood national normalized ratio) is used on PT test results. In made by the liver. It is ces known as clotting This information was w/lab-tests/prothrombin-tim er test looks for D-dimer in ein fragment (small piece) od clot dissolves in your was obtained from: lab-tests/d-dimer-test/#:~: 620a%20protein,once%2 6%20healed.	F 770			
	§483.20(f)(5)Resident-io	dentifiable information				

AND P	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONST	FRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY MPLETED
NAME	OF PROVINCE AS	495201	B. WING				С
	TSIDE HEALTH & REHAB C			4201 GRE	ADDRESS, CITY, STATE, ZIP CODE EENWOOD DRIVE MOUTH, VA 23701	1	0/09/2020
PRE	TIX (EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.) DEFICIENCY)	D RE	(X5) COMPLETION DATE
	resident-identifiable is accordance with a coagrees not to use or except to the extent it to do so. §483.70(i) Medical resease in the extent is to do so. §483.70(i)(1) In accordance in the extent is to do so. §483.70(i)(1) In accordance in the extent is to do so. §483.70(i)(1) In accordance in the extent is to do so. §483.70(i)(2) The faction in the extent is accordance in	to the public. elease information that is to an agent only in outract under which the agent disclose the information the facility itself is permitted cords. rdance with accepted and practices, the facility all records on each resident ented; e; and ganized lity must keep confidential led in the resident's records, or storage method of the release istheir resident permitted by applicable law; enter it permi	F	342			
4 CMS-2	567(02-99) Provinue Vassiana OL			1			

	AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	C. 0938-039 E SURVEY
I				A. BUILDING	3	COM	/PLETED
	NAMEOF	DOMBED OF CHIE	495201	B. WING_			C
		PROVIDER OR SUPPLIER E HEALTH & REHAB CEI	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	10	0/09/2020
ľ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
	PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
		record information againauthorized use. §483.70(i)(4) Medical infor- (i) The period of time in (ii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State information (ii) A record of the residual (iii) A record of the residual (iiii) The comprehensive provided; (iv) The results of any provided; (iv) The results of any provided; (iv) The results of any provided; (iv) Physician's, nurse's, professional's progress (vi) Laboratory, radiolog services reports as required the record review and clinical record review facility staff failed to docinate at every meal on 2020 ADL (Activities of Iffor one of six sampled in the findings included; Resident #6 was admitted.	records must be retained records must be retained required by State law; or date of discharge when t in State law; or s after a resident reaches aw. cal record must contain- n to identify the resident; dent's assessments; e plan of care and services preadmission screening aluations and ded by the State; and other licensed notes; and by and other diagnostic dired under §483.50. In not met as evidenced w, facility document review w, it was determined that cument meal percentage the February and March Daily Living) flow sheets esidents, Resident #6.	F 84	2 F 842 Resident Records – Identifiable Information 1. For Resident #6, the omitted documentation for percentage could not be corrected as time has pass Resident #6 did not experience adverse effects as a this deficient practice. 2. A 100% audit was completed on resident's ADL documentation to ensure staff documented meal peintake at every meal. No other residents were affect this deficient practice. 3. Current licensed nursing staff will be educated o documenting resident's meal percentage intake at emeal. 4. DON or designee will monitor resident records b and as needed to ensure meal percentage is docume every meal. Variances will be reviewed for patterns trends, staff re-educated when deficient practice is i and results reported to QAPI for input and guidance. Date of Compliance: 11.13.2020	food ded. a result of	

STATEMEN' AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	FOOURTHAN	OMB N	O. 0938-0391
THE FLAN (OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	TE SURVEY
NAME OF	PPO//DED OD OUT	495201	B. WING			С
	PROVIDER OR SUPPLIER DE HEALTH & REHAB CE	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		CORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		OKTSMOUTH, VA 23701		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JIII D BE	COMPLETION
r r r p s iii n (v	malnutrition, diabetes (difficulty swallowing) MDS (minimum data 3/17/20; was an admi ARD (assessment ref Resident #6 was code impaired in cognitive is possible 15 on the BII Mental Status) exam. Review of Resident #6 note by the Dietitian of the following: "Food at (Percentage) Breakfast Dinner 25 -50 % Food obtained. Weight Proficinches) lying down, W (pounds) Mechanical is meet residents needs. Diet/Supplements as of as needed and monitor than) 50 % (percent) coweights and po (by moundesired changes." Review of Resident #6 dated 2/12/20 document Resident has increase elated to Dx (Diagnose place. received mechanical in woundesired changes. The condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater and the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance, tolerate leater the condary to Dx. dysphon nutrition to aid in woundaintenance.	stype two and dysphagia b. Resident #6's most recent set) prior to discharge on ission assessment with an ference date) of 2/10/20. ed as being moderately function scoring 11 out of a MS (Brief Interview for S's clinical record revealed a m 2/4/20 that documented md Fluid Intake % st 25-50 %, Lunch 25-50 %, preferences were slie: H (height) 70.0 in / (weight) 176.8 lbs iff scaleIntake does not poor to fair appetiteGoal: prodered. Assist with meals r. Offer substitute if < (less consumedmonitor labs, suth) intake for any 's nutritional care plan med the following: de nutrition/hydration risk ses) w/documented (with) co- appetite stimulant in mically altered diet lagia. Goal: Diet adequate land healing, weight lest (sic) restrictive diet w/ keInterventions: Monitor lated 2/12/20) Offer (percent) of meals.	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPLE CONSTRUCTION	OMB I	NO. 0938-039
and of oblined hold	IDENTIFICATION NUMBER:	A. BUILD		(X3) DA	ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER	495201	B. WING		1	С
PORTSIDE HEALTH & REHAE			STREET ADDRESS, CITY, STATE, ZIP 4201 GREENWOOD DRIVE	CODE	10/09/2020
(X4) ID SUMMAR	Y STATEMENT OF DEFICIENCIES		PORTSMOUTH, VA 23701		
TOUR DEFICE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
under meal percer 2/13/20, 2/15/20, 2/23/20, 2/25/20, 2/23/20, 2/25/20, 2/31/20. All three r those dates. Review of Resident tracking form reveat following dates und 3/1/20, 3/5/20, 3/8/1 through 3/21/20 and three meals were ndates. On 10/8/20 at appresinterview was condinurse) #1, a nurse of When asked about stated that nursing sencourage Resident some days he was sence days and that some some meals. RN #1 aware of his poor apmuch better on days sit with him. When a spaces meant on the RN #1 stated that the forgot to chart. RN # aides usually document the ADL flow sheet. Fin February and Marcopercentages were be chart. RN #1 stated the now being document, and the system will all	Living) tracking form revealed nk spots) for the following dates ntage for Eating: 2/11/20, 2/18/20, 2/19/20, 2/22/20, 2/27/20, 2/28/20, 2/30/20, meals were not documented on at #6's March 2020 ADL aled several holes for the der meal percentage for Eating: 20 through 3/15/20; 3/18/20 d 3/23/20 through 3/30/20. All not documented on the those acceptable with RN (registered familiar with Resident #6. resident #6's appetite, RN #1 staff would have to frequently the following that the family was petite and that his intake was at the sister would come in and sked what "holes" or blank as a ADL flow sheet for eating, an ursing aides must have a stated that the nursing ented meal percentage on RN #1 also stated that back ch of 2020 meals are in the computer system left nursing staff if completed. RN #1 stated	F			

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391	
2 01	OSINEOTION	IDENTIFICATION NUMBER:	A. BUILD	ING	UND I KUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF D	201 //2	495201	B. WING				С	
NAME OF PE	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	1	0/09/2020	
PORTSIDE	HEALTH & REHAB C	ENTER		4201	GREENWOOD DRIVE			
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		FUR	TSMOUTH, VA 23701			
PREFIX TAG	(EACH DEFICIENC	CYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
r ff h s s s a ref R sh h w h c ar no st. be RI ins ope #60 see pe cool Fur rev we On Adi Nui con	was being completed behind her nursing aid accurate documentate usually went behind the stated that she wasn't nursing aides were not allow sheet. When ask his meal intake if there is paces on the ADL flowshe was aware that Respective but there were fusing all three meaks according all three meaks are that the nursing all three meaks are that the nursing are if Resident #6 would always and the wasness where the wasness where she of the theory of the wasness where she of the theory of the wasness where she of the wasness wasness where the wasness wasness where she of the wasness wasness where she of the wasness wa	also supposed to go behind ensure all documentation d. When asked if she went ides to ensure complete and tion, RN #1 stated that MDS them every month. RN #1 it even aware that the ot documenting on the ADL and how she was to monitor the were days of blank ow record, RN #1 stated that desident #6 had a poor the never days of him als. RN #1 stated that ways eat something. RN #1 graides would have alerted used all meals and then she had all meals and then she had alternate meals for 50 percent; if intake was the clinical record, RN #1 of sure; that she may have beally by the nursing aide. That she had a poor that far back if any specific ferred alternate food. When asked if Resident is complete if there were paces under meal ted, "No, it's not a rid." The sure of the allower of are of the above	F8	342	JEN ISIENCTY			

STATEMENT OF	DEFICIENCIES	(X1) PROVIDED OUT TO THE			
AND PLAN OF C	ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	OMB NO. 093 (X3) DATE SURV COMPLETE
		495201	B. WING_		C
NAME OF PROV	VIDER OR SUPPLIER		B. WING		10/09/20
PORTSIDE H	EALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	10/09/20
(X4) ID PREFIX TAG	(CACIT DEFICIENT:Y	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORPORATION	D.D.E.
Fa ad	idioss rife above col	ecord Retention," did not	F 84		
CO	inplete medical reco	ord. was presented prior to exit.			
MS operation	^P revious Versions Obsolete				