STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING ______ B. WING ______	C 11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 11/16/20 and continued with offsite review 11/17/20 through 11/20/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted onsite 11/16/20 and continued with offsite review 11/17/20 through 11/20/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. The census in this 209 certified bed facility was 185 at the time of survey. Thirty-three residents had tested positive for COVID-19, all have recovered. Twenty-seven employees has tested positive and 24 have recovered.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		1/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/29/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, clinical record review, and review of the facility's policy, the facility staff failed to notify the resident	F 580	Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth	

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F 580

Continued From page 2

representative of a deterioration in health for 1 of 9 residents (Resident #1), in the survey sample.

The findings included:

Resident #1 was originally admitted to the facility 8/28/2013, and was discharged to an acute care hospital on 8/20/20 with return anticipated. The resident returned to the nursing facility on 8/28/20. Resident #1's diagnoses included COPD, dementia, heart failure and diabetes.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/17/20, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, eating, and toileting, as well as total care of one person with bathing.

Review of Resident #1 clinical record revealed on 6/4/20 at 4:01 a.m., the resident presented with expiratory wheezing which required nebulizer treatments as well as oxygen therapy. The clinical record also stated the resident complained about her stomach hurting and the need to vomit. The clinical record further stated on 6/5/20 at 5:01 a.m., the resident was awake the majority of the night complaining of stomach pains, an achy body, feeling bad and stating that "she was dying". The clinical record further revealed the provider was "flagged" to evaluate the resident for the noted concerns.

F 580

of the fact alleged or of any conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State laws

1. On 6/6/20 residents # 1 deterioration of health was communicated to the responsible representative (RR).
2. The nurse was educated by the DON on the requirement of responsible representative notification of deterioration in health. The nurse□s notes for the last 7 days will be reviewed by the DON/designee for RR notification of resident□s deterioration in health. Notification will be made by the DON or designee if none are documented.
3. The DON/designee will review the 24 hour report to identify residents who are declining requiring RR notification, change in condition and verify notifications are communicated and documented to the RR. Clinical educator/designee will provide education to nursing staff on notification of changes in condition in a resident and that notification must be documented in the EMR by 1/4/21.
4. The Nurse Manager/designee will audit four charts weekly x 4 weeks, then two resident weekly x 8 weeks to ensure any significant change in physical condition have been reported to the responsible representative where applicable. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.

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On 6/5/20, (time unknown) the Nurse Practitioner (NP) evaluated the resident for rapid breathing for two days, expiratory wheezing and increased use of "as needed" inhalers. The NP ordered a stat (immediate) chest x-ray and continuation of inhalers.

On 6/5/20 at 11:52 p.m., the chest x-ray results were sent to the facility and the on-call physician was notified of the results. At 2:44 a.m., on 6/6/20, the clinical record revealed the resident representative was notified of the resident's transfer to a local hospital for further evaluation.

The clinical record revealed no documentation that the resident representative was notified of the change in the resident condition when "as needed" interventions were necessary 6/4/20 and 6/5/20, and an evaluation by the practitioner was necessary for what was described as follows; "faint expiratory wheezing heard throughout with diffuse rales (crackling noises that may be made by the lungs) in the base." The practitioner plan for care included a stat (immediate) chest x-ray and to continue the Albuterol (a bronchodilator) and Pulmicort (a corticosteroid) inhaler.

On 11/20/20 at approximately 9:00 a.m., the above information was shared with the Administrator and the facility's team. An opportunity was afforded the facility's staff to provide additional information however no additional information was presented.

The facility's policy titled Notification of Changes with a revision date of 3/20 stated "except in an emergency or when a resident is incompetent, the facility will consult with the resident immediately and notify the resident's physician,

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F 580	Continued From page 4 the resident's legal representative or family members as soon as possible and no greater than 24 hours when there is the following: An accident involving the resident that results in injury. A significant change in the resident physical, mental or psychological status. A need to alter treatment significantly. A decision to transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. COMPLAINT DEFICIENCY.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, clinical record review, and facility documentation, the facility staff failed to ensure significant medications were administered to 1 of 9 residents (Resident #9), in the survey sample. The facility staff failed to administer Resident #9 the following significant medications as ordered by the physician: Amlodipine 5 mg, Hydralazine 25 mg, Imdur 60 mg, Lopressor 25 mg and Seroquel 25 mg. The findings include: Resident #9 was admitted to the nursing facility on 10/26/2019 and discharged to the hospital on	F 658	It is noted that according to the Medication Administration Record signed by the RN that cared for Resident #9, medications were administered on 10/26/2020 at approximately 10:43pm. The Administrator shared this information for consideration with the surveyor prior to exit conference conducted on 11/20/2020 at 3:08pm. The "no additional information" comment occurred only after considerable discussion had already occurred. Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in the statement of deficiencies.	1/4/21

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F 658	Continued From page 5 10/27/2019. Diagnoses included but not limited to; Hypertension (high blood pressure) and Dementia with behaviors. The resident's Minimum Data Set (MDS) assessment was not due. A phone interview was conducted with Resident #9's granddaughter on 11/20/20 at approximately 10:40 a.m. The granddaughter stated she arrived to the nursing facility on 10/26/19 at approximately 5:00 p.m., the same time Resident #9 arrived by ambulance. The granddaughter said she asked Registered Nurse (RN) #1 if he was going to give Resident #9 his nighttime medications because it was getting late. The granddaughter said the RN stated, "Yes, I will go and get them right now." The granddaughter said the RN never came back to administer Resident #9's his medications. The granddaughter said she never left the room. She said "My mother arrived at the facility around 11:30 p.m.; we switched places; I left and my mother took over." The granddaughter said she informed her mother that the nurse (RN #1) never gave Resident #9 any of his nighttime medications. On 11/17/20 at approximately 11:05 a.m., a phone interview was conducted with Resident #9's daughter. The daughter said she relieved her daughter around 11:30 p.m., on (10/26/19) and stated "My daughter informed me that she had ask the nurse if he was going to give Resident #9 his bedtime medications and he stated, "Yes" but he never came back." The daughter said she stayed with Resident #9 all night and never left the room and no one ever came in to bring Resident #9 his medications. The daughter voiced concerns that Resident #9	F 658	This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State laws. 1. Resident #9 no longer resides in the facility as of 10/27/20. 2. The DON/designee will audit 10 new admissions from the past seven days to determine if the medications were given and where they were obtained. 3. The DON/designee will review the 24 hour report for new admissions and review medication administration records to determine where the medications were obtained and given as ordered. The educator will educate the licensed nursing staff on the process for obtaining medications from the stat box and MediBank system and documents that need to be completed for that process. 4. The DON/designee will audit four new admission medication administration records weekly for 4 weeks and two medication administration records weekly for eight weeks to determine where the medications were obtained and documentation is completed. The results of the audits will be reported at the QA meeting by the Pharmacy Representative/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 658	Continued From page 6	F 658		

was on many cardiac medications and takes Seroquel at night for his behaviors. She said Resident #9 was and up and down most of the night and being combative. The daughter said the Seroquel keeps him calm, which allows him to sleep and rest at night.

On 11/17/20 at approximately 10:30 a.m., a phone interview was conducted with Registered Nurse (RN) #1. RN #1 was the receiving nurse for Resident #9, day of his admission. The nurse said he could not recall Resident #9 or his family. When asked what happens if a newly admitted resident, medications have not been delivered by pharmacy. The nurse said the residents orders are verified, pulled from the Stat Box, Emergency Box or Pyxis Machine. A slip is filled out with the residents name, medication and date. The slip(s) are placed back inside the stat or emergency box. The RN stated, "If I signed off medication were given, then I must have given them."

Review of the Medication Administration History Report for October 2020 was documented the following medications were signed off as being administrated on 10/26/19 at approximately 10:43 p.m., Amlodipine 5 mg, Baclofen 5 mg, Hydralazine 25 mg, Imdur ER 60 mg, Lopressor 50 mg and Seroquel 50 mg.

A phone interview was conducted with Licensed Practical Nurse (LPN) #3 on 11/17/20 at approximately 10:37 a.m. The LPN said Resident #9's daughter was upset and crying. The LPN said the resident's daughter said the night nurse did not give Resident #9's nighttime medications. She said Resident #9 is on scheduled Seroquel, which keeps, him calm and if he had received his Seroquel he would have not been combative or

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F 658	Continued From page 7	F 658		

trying to get up. The LPN said the daughter stated, "There is no way Resident #9 can participate in therapy." The LPN said Resident #9's daughter left the room, when she returned, the daughter said she had called 911 to have Resident #9 transferred back to the hospital.

Review of Resident #9's Physician Order Sheet (POS) for October 2019 revealed the following medications to be administered at bedtime starting on 10/26/19 between (9 PM - 10 PM.)
Amlodipine 5 mg two times daily for high blood pressure.
Baclofen 5 mg twice daily starting for Muscle Spasms.
Hydralazine 25 mg twice daily starting for high blood pressure.
Imdur ER 60 mg twice daily starting for high blood pressure.
Lopressor 50 mg twice daily starting for high blood pressure.
Seroquel 50 mg at hour of sleep for Dementia with Behaviors.

*Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/ency/article/007365.htm).

On 11/19/20 at approximately 10:30 a.m., a conference call was conducted with the Administrator, Cooperate and two other team members. The surveyor requested the medication slips to show Resident #9's

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F 658	Continued From page 8	F 658		

medications where pulled from the stat box. The team said they had spoken with a representative at (name of pharmacy) and were informed they only keep the slips from the stat box for one year. A request was made to provide evidence the time pharmacy delivered Resident #9's medications to the facility on 10/26/19.

A phone interview was conducted with the General Manager (GM) at (name of pharmacy) on 11/19/20 at approximately 3:49 p.m. The GM said "We keep our receipts for 5 years (regular medication) and seven years for controlled medications." He said they went through all the boxes in the pharmacy (around the time Resident #9 was admitted to the nursing facility) and was unable to locate slips to show the medications where pulled from the stat box. The GM proceeded to say that if the facility fails to complete a slip after pulling medication from the stat box, once the stat box is returned to the pharmacy, the stat box is audited and if drugs were missing, the facility is billed for the missing medication(s). The GM said the facility was never billed for missing medications. The GM stated, "That's why the facilities are encouraged to keep their slips for situations like this." The GM stated, "The facility was made aware we could not validate medications were pulled from the stat box for (Resident #9) on 10/26/19.

On 11/19/20 at approximately 6:45 p.m., the Administrator provided Resident #9's medication invoice from (name of pharmacy.) The invoice did not have a date or time the medications were delivered to the nursing facility. Resident #9's medications were reviewed and compared to the medications in the facility's stat box and revealed all scheduled medications to be administered to

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F 658	Continued From page 9 Resident #9 between (9 PM-10 PM) were in the stat box. Documentation provided by the facility revealed all the medications that Resident #9 was scheduled to receive on 10/26/19 were located in the Medi Bank (Stat Box). Amlodipine 5 mg (6 tablets) Baclofen 10 mg (4 tablets) Hydralazine 25 mg (4 tablets) Imdur ER 30 mg (4 tablets) Lopressor 25 mg (4 tablets) Seroquel 25 mg (8 tablets) On 11/20/20 at approximately 3:08 p.m., the above information was shared with the Administrator and Administrative team. When asked if (name of pharmacy) provided documentation on the time Resident #9's medications arrived to the facility on 10/26/19, the Administrator stated, "No additional information." When asked, "How long does the facility keep the carbon copy of the medication slips from the stat box for their records," the Administrator replied, "No comment." The Executive Director of (name of pharmacy) provided the following information on 12/01/20 at approximately 10:32 a.m. Resident #9's medication arrived at the nursing facility on 10/28/19 at approximately 4:42 a.m. The document included this information was also provided to the facility.	F 658		
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 -	F 689		1/4/21

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F 689	Continued From page 10 §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 observation, staff interviews, closed record review, and in the course of a complaint investigation, the facility staff failed to ensure fall prevention interventions were implemented for two Residents (Resident #2 and Resident #3) in a survey sample of 9 residents. The findings included: 1. For Resident #2, the facility staff failed to provide supervision while in the dining room. Resident #2 was originally admitted to the facility 12/05/19 and expired on 4/27/20. Resident #2's diagnoses included Difficulty walking, Unsteadiness on feet and Repeated Falls. The Significant Change minimum data set assessment (MDS) with an assessment reference date (ARD) of 02/21/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of possible 15. This indicated Resident #2's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with transfers, bed mobility, transfers, locomotion, toileting, and bathing. Requiring limited assistance with dressing and personal hygiene and required supervision with eating.	F 689	Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or of any conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State laws. 1. Resident #2 no longer resides in the facility as of 4/27/20. 2. The DON/designee will review residents on the Monticello unit who are at risk for falling care plan to ensure the fall interventions are in place. 3. Nursing staff will be educated on following the care plan interventions by the educator/designee. For those who require supervision in the dining room a team member will be assigned to the area during meals. 4. Unit Managers/designees will audit records of four residents identified as at risk for falls per unit x 8 weeks to ensure all identified interventions are documented and if residents require supervision during meals a team member is present. The results of the audits will be reported at the QA meeting by the Unit Managers/designees for evaluation of compliance and ongoing monitoring for	

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F 689	Continued From page 11 The Nursing facility progress notes were reviewed and revealed the following: Progress note dated 2/27/20 at 5:05 p.m. reads: Resident observed sitting in the dining floor next to WC (Wheel Chair). She had her left hand on the floor and her right hand holding the right side of her forehead. She is alert and verbal. Resident stated that she hit the right side of her forehead. Resident verbalized that she was attempting to get out of the WC to ambulate on her own. Upon assessment, a hematoma is present on right lateral side of her forehead. Ecchymosis to right eye noted. Ice applied as tolerated. A small skin tear also observed on right inner thumb; slightly bleeding. Cleansed per facility protocol. Denies pain. PERLA (Pupils Equal and Reactive to Light and accommodation). Full Range of Motion to all extremities. Initiated neuro checks. Assisted back to WC using total lift x 2 staff assist. PRN (as needed) Ativan administered; ineffective. Resident placed in common area to provide constant monitoring. Education and frequent redirection given. NP (Nurse Practitioner) notified. RP (Responsible Party/Person) made aware. Progress note dated 2/29/29 reads: Resident alert in Geri- chair at this time. Resident is a fall risk and trying to get up and walk. Resident is post fall day two and has been placed by nurse's station for observation at this time. NAD (No Acute Distress) observed. Will continue to monitor. A review of staff witness statements reveal the following: Dated 2/27/20 Reads: I was going into the dining room to get some tea for a resident when I saw Resident #2 lying on the floor and called out for	F 689	continuous improvement analysis.	

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help. No staff member was in the dining room at that time.

Review of progress note dated 3/06/20 read: She suffered significant facial bruising from fall on 2/26/20.

Review of progress note dated 4/25/20 at 11:40 p.m. Reads: 3 (PM.)-11 (PM) nurse as she was passing room reads Resident slid out of the bed on to floor mats. Bed was in lowest position and call bell within reach. No injuries noted.

On 11/18/20 at 9:15 a.m. an interview was conducted with LPN (Licensed Practical Nurse) #5 concerning the above Resident #2's falls. She stated, "I only worked on the (Name) Unit with her for a couple of weeks. She was very confused and declining due to her brain tumor. She had a major fall on my unit in the dining area. They were setting up for lunch when she fell from the wheel chair. There was an assistant assigned to feed her. I'm not sure if she was there. We had two residents present. When I called the daughter I stated (there was a) hematoma to her eye. We got her up in the geri-chair. I asked the daughter if she could come in. She came two days later. The daughter thought someone abused her. I reported the allegations to the manager."

On 11/18/20 at 10:20 a.m. an interview was conducted with LPN #2 concerning Resident #2's falls. She stated, "Generally speaking, interventions like fall mats, when in the bed, low bed, frequently used items in arms reach. Therapy evaluation for persistent falls. She had a brain tumor and dementia so she had increased confusion at times and would get up unassisted. I don't think she understood that the call bell was

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there if she needed assistance due to the confusion she had. She had hip protectors, non-skid socks."

On 11/18/20 at 9:45 a.m. an interview was conducted with the Restorative Aide (Certified Nursing Assistant/CNA #4) regarding Resident #2's falls. She stated, "She tried to get out of the bed and fell. No injuries on one occasion. She had on hip protectors, floor mats. We did rounds every one or two hours. We would put her in her wheelchair or Geri chair near the nurses' station."

An interview was conducted on 11/18/20 at 9:55 a.m. with CNA #5 concerning Resident #2. She stated, "I assisted her when I was a CNA on the (Name) Unit. I'm currently on the (Name) unit. I would assist her in the dining room when she would undress. She would take off her shirt and I would put it back on. We would put a blanket on her. I've never seen her take her pants off." She was asked if she had ever witnessed Resident #2 falling. She stated, "No ma'am."

On 11/18/20 at 10:00 a.m. an interview was conducted with LPN #4 concerning Resident #2. She stated, "She was very difficult to redirect and confused. Very high risk, had several falls while on our unit. Her prevention required supervision, one on one when time available. We took turns keeping our eyes on her making sure that she didn't fall. I was at the nurse's station when she fell in the dining room. I wasn't present. They said that she fell and hit her head. I don't remember anything after the fall."

Care plan reads: Problems: Resident has a history of falls since admission and prior admission: within last month.

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Fall history:
12/15/19 unwitnessed fall, attempting to toilet, no injury.
1/13/20 unwitnessed fall, no injury, attempting to toilet.
2/26/20 unwitnessed fall in room.
2/27/20 unwitnessed fall in the dining room.
3/06/20 unwitnessed fall.
3/07/20 unwitnessed fall in the room-resisted staff assistance to get off the floor.
3/10/20 witnessed fall x 2 at nurses station, from Geri-chair, hitting and kicking staff. Effective 12/16/19-Present.

Care Plan Goals: Resident will maintain current level of mobility with no increase in the incidence of falls/injuries. Effective 12/16/19-Present. Interventions: Assist resident to wear non-slick footwear that fits. Effective 12/16/19-Present. Engage resident in activities that improve strength, balance and posture. Instruct resident on safety measures to reduce the risk of falls. Keep areas free of obstructions to reduce the risk of falls and injury. Hip protectors to be worn at all times. Remind resident to call for assistance when ambulating or transferring (Effective 1/14/20-Present). Monitor patient more often when in room (Effective 2/26/20-Present). Keep nurse call light within easy reach. Instruct resident to use call bell or call out for assistance. Effective 12/16/19-Present.

An exit interview was conducted with the Administrator and corporate staff on 11/20/20. No additional information was provided by the facility staff.

2. For Resident #3 was originally admitted to the facility 08/09/17 and readmitted on 11/03/19.

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Resident #3's diagnoses includes difficulty walking.

The Quarterly Review minimum data set assessment with an assessment reference date (ARD) of 10/01/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring a 7 out of 15. This indicated Resident # 3's cognitive abilities for daily decision making is severely impaired.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, locomotion on and off the unit, limited assistance with transfers, dressing, and toilet use and supervision with eating and personal hygiene.

On 11/16/20 at 1:10 p.m. during the initial tour, Resident #3 was seen sitting on the right side of her bed eating lunch. The call bells were not in reach and the cord was entangled on the left side of her bedrail. CNA (Certified Nursing Assistant) #7 walked into the room, untangled the two call bells with difficulty and placed them on the bed near the resident. LPN #2 walked in shortly thereafter and clipped one of the call bells onto the bed linen near the resident and placed the adaptive call bell closer to the resident.

On 11/19/20 at 1:34 p.m. an interview was conducted with CNA #7 concerning the above incident. She stated, "She (Resident) had used it earlier (call bell). It was beside the bed. It should be on the bed but she (Resident) moved it. She was asked what prevention measures are in place to keep the resident from falling. She stated, "Make sure she has fall mat at her bed, call bell, and the hip protector on. Bed in low

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F 689	Continued From page 16 position. Rounding-every hour." On 11/19/20 at 1:46 p.m. an interview was conducted with LPN #6, She was asked what contributed to Resident having a history of falls. She stated, "Her trying to transfer without assistance." A review of Resident's Care Plan Reads: Problems: Resident has risks of falls and/or injury of falls related to refusal to be compliant with assistive and ambulatory devices. Effective 11/09/17- Present. Goals: Resident will not experience significant injury. Through next review. Preventions: Keep call bell in reach; provide adaptive call bell as needed. A review of progress notes dated 4/25/20 read: Resident was found on the floor in the bathroom in front of the toilet seat. Stated that she slid off the floor. She did not fall. Supervisor made aware. MD and Responsible party notified. A review of nursing notes dated 8/15/20 revealed: Resident had a non-witnessed fall this morning. Nurse noticed upon coming on duty 7 AM-3 PM shift. Resident was on the floor. There was no injuries noted at this time. Daughter was notified. An exit interview was conducted with the Administrator and corporate staff on 11/20/20. No additional information was provided by the facility staff.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		1/4/21

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F 692	Continued From page 17 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, closed record review, and in the course of a complaint investigation, the facility staff failed to meals as ordered to one Resident (Resident #2) and failed to ensure meals were consumed and/or documented for one resident (Resident #4) in a survey sample of 9 residents. The findings included: 1. Resident #2 was originally admitted to the facility 12/05/19 and expired on 4/27/20. Resident #2 diagnoses included Difficulty walking, Unsteadiness on feet and Repeated Falls. The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/21/20 coded the	F 692	Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State laws. 1. Resident #2 no longer resides in the facility as of 4/27/20. Resident #4 meals are currently being documented in the EMR. 2. The Food Service Director (FSD)/designee will observe that current residents on the Monticello unit are receiving a therapeutic diet as ordered. DON/designee will review documentation	

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F 692	Continued From page 18 resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of possible 15. This indicated Resident #2's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with transfers, bed mobility, transfers, locomotion, toileting, and bathing. Requiring limited assistance with dressing and personal hygiene and required supervision with eating. A review of the Facility Reported Incident (FRI) reads: Date of Occurrence: 2/14/20 Date of this report: 2/15/20. At approximately 11:45 a.m. today, the daughter of the above named resident (Resident #2) informed facility administration that her mother's evening dinner was not provided to her as ordered, nor in a timely fashion, the Nurse Aide assigned to her mother. Instead, she said, that only after intervention by her mother's roommate (who provided her with verbal account) and other staff did her mother receive a substitute meal. An investigation into the incident was immediately launched. Employee Action Initiated or Taken: Suspended pending investigation. A review of Resident's missed meal consumption record revealed the following: 2/02/20 Dinner intake = not recorded. 2/06/20 Breakfast and Lunch intake = not recorded. 2/07/20 Lunch and Dinner intake =not recorded. 2/09/20 Breakfast and Lunch intake = not recorded. 2/10/20 Dinner intake = not recorded 2/13/20 Dinner intake =not recorded. 2/14/20 Breakfast intake =80%, Lunch intake =90%, Dinner intake = 30% (Resident #2	F 692	on the Monticello unit to ensure meals are consumed and documented as appropriate. 3. The Clinical Educator/designee will educate nursing staff on importance of residents receiving diet as ordered and that after meals are consumed they are documented appropriately in the EMR. 4. The Food Service Director/designee will audit to ensure a therapeutic diet is prepared for 4 residents weekly for 4 weeks and then 2 residents weekly for 8 weeks. The Nurse Manager/designee will audit meal consumption documentation on four residents weekly for 4 weeks and then two residents weekly for 8 weeks. The results of the audits will be reported at the QA meeting by the ADON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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received meals).
2/15/20 Breakfast intake and Lunch intake = not recorded.
2/21/20 Dinner intake = not recorded.
2/27/20 Lunch and Dinner intake=not recorded.

A review of Resident's Care Plan reads:
Problems: At risk for compromised nutritional and hydration status secondary to current medical status and advanced age. P.O. (by mouth) intake less than 75%. Goals: Will have no unmet hunger/thirst needs over the next review period. Interventions: Offer assistance with meals as needed, Monitor for decline in ability to feed self. Effective 12/17/19-Present.

On 11/18/20 at 9:15 a.m. an interview was conducted with LPN #5 concerning Resident #2 missing meals. She stated, "We made a feeding list due to the different CNA's (Certified Nursing Assistants) coming over (to the unit). We did a huddle that week. The nurse (LPN #4) explained to the police what happened. She didn't get weights. She was declining and appeared to be in a lot of pain."

On 11/18/20 at 9:45 a.m. an interview was conducted with CNA #4 concerning feeding Resident #2. She stated, "She required assistance with feeding. She was not able to feed herself. She was a maximum assist. She was very confused. She was asked if Resident #2 was able to make her needs known. She replied, "No."

On 11/18/20 at 12:20 p.m. An interview was conducted with SW (Social Worker/Other Staff on (Name) Unit) #1. She stated, "She missed one meal and was provided a boxed meal with a sandwich in it. I started my visits on February

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28th for 4 weeks. I would visit with resident. She was verbal and would know what was going on. I was making sure she was getting her meals on time. There were no complaints. Initially, the unit manager spoke to the CNA reported for not feeding her."

On 11/19/20 at 10:15 a.m. a telephone interview was conducted with Resident #5 (Resident #2's former roommate). She stated, Her name was (stating Resident #2's last name). She was always getting out of her bed. Packing stuff." "First night no tray was brought in. It's happen to me before. They sent my tray back to the kitchen. Then it ended up being a sandwich and chips." "Two nights resident didn't get food. The CNA said oh well. I told the nurse, she said they ordered something from kitchen. Half an hour later the nurse asked me if CNA had come in to feed resident #2. I said no. Then the shift changed. They said the kitchen was closed." Resident #5 stated "The Second night no tray came to my room. She didn't get the tray until after 9 p.m." "The kitchen closes at 7 p.m. They brought sandwich and chips."

A review of a complaint allegation dated 5/28/20 included that Resident #2 was not provided any meals on 3/12/20-3/15/20. The meal consumption listed below reveals that Resident #2 didn't receive meals on the following dates:
*3/14/20 Lunch intake = % not recorded.
*3/15/20 Lunch and Dinner intake = % not recorded.
*3/16/20 Dinner = not recorded.

An exit interview was conducted with the Administrator and corporate staff on 11/20/20. No comments were voiced.

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2. For Resident #4 was originally admitted to the facility 07/16/19 and was re-admitted on 12/26/19 and Resident #4 diagnoses included Dysphagia.

The Quarterly Review Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/27/20. The staff assessment for mental status shows resident as having long term and short term memory problems. Resident's cognitive skills for decision making shows resident is severely impaired.

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

Resident #4's Care Plan read: At risk of compromised nutritional hydration status secondary to current medical status. At risk for aspiration and weight loss. Goals: Will maintain weight within 5% per month within the next review period. Will increase/maintain PO intake of 75% or greater over the next review period. Interventions: Obtain weights per facility protocol, offer assistance with meals as needed, assess for signs/symptoms of aspirations during PO (oral intake). Effective 7/26/20-Present.

The Physician Order Summary Read: Chopped meat. Mechanical altered. Dysphagia. Diet: Thin water only after oral care and not with meals. Swallow precautions. Take small bites/small sips make sure mouth is clear before next bite. Maximal meal assistance. Order date: 9/02/19

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F 692	Continued From page 22 A review of Resident's missed meal consumption record revealed the following: 9/02/20 Dinner intake % not recorded. 9/03/20 no meal % recorded 9/04/20 Dinner intake % not recorded. 9/08/20 Dinner intake % not recorded. 9/11/20 Dinner intake not recorded. 9/13/20 Breakfast and Lunch intake % not recorded. 9/18/20 Dinner intake % not recorded. 9/28/20-10/06/20 Dinner intake % not recorded. 10/07/20-10/08/20 Lunch and Dinner intake not recorded. 10/12/20-10/13/20-Dinner intake not recorded. 10/20/20-10/22/20- Dinner intake not recorded. 11/01/20-11/03/20-Dinner intake not recorded. On 11/16/20 at 12:40 p.m. Resident #4 was observed during the initial tour being fed by CNA #8. His CNA asked him if he wanted more. He stated, "No." "I feel big." He consumed 75% of his lunch. His meal consisted of Sloppy Joe, green beans, ice cream, thickened juice and a parfait. On 11/18/20 at 10:20 a.m. an interview was conducted with LPN (Licensed Practical Nurse) #2 concerning Resident #4. She was asked if Resident experienced any issues with staff not feeding him his meals or not receiving trays at meal time. She stated, "No ma'am." He weighs 122.7 lbs. as of today. Was in 140's in January. Placed on a supplement-magic cup. Intake on a continuous basis 75% all meals. Chopped meat, low concentrated treats. Not much of a change. Receives a Magic cup at lunch and at dinner." On 11/18/20 at 10:44 a.m. an interview was conducted with the Dietitian (Other staff #3) concerning Resident #4. She stated, "He was	F 692		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WARWICK FOREST	**1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602**

(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
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doing pretty well and then I saw a decrease on 11/04/20 with his weight.(120 lbs.), We would do weekly weights x 4 weeks. His PO intakes are the same. His mother used to bring in snacks before COVID. He's on a Nectar thick liquid diet. Maybe add ensure puddings. His mom would go to McDonalds. His weight today is 122.7 lbs. Prevention measures in place now are snacks and double portions. Prior to that he was getting magic cups at lunch and dinner and staff assist with meals."

On 11/18/20 at 3:45 p.m. an interview was conducted with CNA (Certified Nurse Aide) #6 concerning Resident #4. She stated, "I have him for dinner he eats 100% for dinner. Before COVID his mom was coming and bringing resident lots of snacks, chips, junk food and soda. He tells me when he's hungry and tired. I feed him every evening shift and the other aides feed him during the day."

An exit interview was conducted with the Administrator and corporate staff on 11/20/20. No comments were voiced.