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	495068	A. BUILDING _____ B. WING _____	C 08/03/2020

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SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted remotely 7/29/20 through 7/31/20 and 8/3/20. Two complaints were investigated during the course of survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 169 bed facility was 119 at the time of survey. The survey sample consisted of two current records (Resident #1 and #3) and one closed record (Resident #2).	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure one of two sampled residents (Resident #1) who required dialysis received care and services consistent with professional standards of practice, the comprehensive-centered care plan, and the resident's goals and preferences. 1 a. For Resident #1, facility staff failed to coordinate dialysis services upon admission resulting in Resident #1 being sent to the emergency room to be dialyzed on 6/27/20 and 6/30/20; failed to ensure an order was in place for	F 698	1. a. Dialysis services has been arranged to Resident #1. A dialysis order has been implemented for Resident #1 and the comprehensive care plan has been updated to reflect the same. b. The facility has obtained and established ongoing communication with the dialysis center for Resident #1. c. Physician has been notified of Resident #1 missed dialysis appointment on 7/11/20.	8/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/07/2020

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F 698	Continued From page 1 dialysis in a timely manner, and failed to ensure the comprehensive care plan was accurate to reflect his dialysis orders. 1 b. For Resident #1, facility staff failed to provide evidence of ongoing communication with the dialysis center before and after scheduled dialysis appointments. 1 c. Facility staff failed to notify the physician regarding Resident #1's missed dialysis appointment on 7/11/20. The findings included: 1 a. Resident #1 was admitted to the facility on 6/26/20 with diagnoses that included but were not limited to, COVID-19, and end stage renal disease requiring dialysis. Resident #1's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/2/20. Resident #1 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #1's hospital course summary documented the following: "End Stage Renal Disease on HD (Hemodialysis). Nephrology was following, continue scheduled dialysis TTS (Thursday through Saturday)...Last HD was on 6/25...Patient Instructions: Follow up with nephrology team with Hemodialysis or in 2-3 weeks." Review of Resident #1's nursing notes revealed that Resident #1 was admitted to the facility on 6/26/20 at approximately 7 p.m. A late entry note dated 6/27/20 at 7:06 a.m. documented in part,	F 698	2. Audit completed of dialysis residents to ensure validation of dialysis services has been arranged along with a dialysis order and a comprehensive care plan is in place. Audit completed of dialysis residents to ensure evidence of ongoing communication is in place. Audit completed of dialysis residents to ensure physician has been notified of any missed dialysis appointments. This presence of this information will also be validated on all newly admitted resident receiving dialysis services. This was completed by 8/7/20. 3. Education on the Care of End Stage Renal Disease Resident Policy was provided to the Licensed Nurses by 8/10/20. This training will also be provided to all Licensed Nurses upon hire and during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure resident dialysis services have been arranged, a dialysis order is in place along with a comprehensive care plan. Ongoing audits will also be conducted to ensure evidence of ongoing communication is in place and the physicians have been notified of any missed dialysis appointments. These audits will be conducted 3 x week for 4 weeks, weekly for two weeks, and monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends	

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F 698	Continued From page 2 the following: "...received resident approx (approximately). 7 p (p.m.) via stretcher accompanied by 2 EMT (Emergency Medical Technician) drivers 63 year old male dx (diagnoses) pneumonia, covid +...ESRD (End stage renal disease)...alert and oriented x 4...HD dialysis resident able to make needs known..." Review of Resident #1's admissions orders dated 6/26/20, failed to evidence an order for Resident #1's dialysis days, location and chair time. A note dated 6/27/20 at 10:10 a.m., documented the following: "Call received from (Name of dialysis center) in regards to resident missing scheduled dialysis, spoke with the nurse and stated that it was too late for resident to come and that he needed to go to ER (Emergency room) to have dialysis per nephrologist. Called placed to Fast Track (Name of Transport), stated that they would have a crew here to transport at 12 p.m. Resident made aware of all mentioned above. No distress noted at this time." The next note dated 6/27/20 at 18:08 (6:08 p.m.) documented the following: "call placed to (Name of ER) to check on resident d/t (due to) been sent for dialysis (Sic) Spoke to (Name of Nurse) RN, stated that resident had just finished dialysis..." On 6/30/20, it was revealed through Resident #1's nursing notes that Resident #1 went back to the Emergency Room for Dialysis. The following note was written: "resident was transported via stretcher by transport co. (company) to HD (Hemo Dialysis) center at (Name of ER). ...face sheet, and dialysis hand off communication form in binder left with him."	F 698	identified will be addressed by the QAPI committee as they are arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 8/14/20.	

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F 698	Continued From page 3 On 7/31/20 at 2:11 p.m., The ADON (Assistant Director of Nursing) provided evidence that she had followed up with Resident #1's dialysis on 6/30/20 after his second missed dialysis treatment at the Dialysis center. The following was documented in an email to the scheduler: "...his info is (Name of Dialysis Center), (Dialysis address), Tu, Thurs, and Sat, chair time is 7 a.m. and pick up time is 11:30 (pick up time back to facility)." A physician's order was still not put into place after this information was obtained on 6/30/20. Review of Resident #1's July POS (Physician Order Summary) revealed an order was not put into place until 7/22/20. The following order was documented: "Dialysis: Receives Dialysis @ (at) (Name of Dialysis Center) @ (address documented) on M, W, F - Pick up time: 8:30 a.m. Chair time 9:30 a.m." Review of Resident #1's care plan dated 6/26/20 and revised 7/14/20 documented the following intervention: "Dialysis: Receives Dialysis @ (Name of wrong dialysis center) at (address of Dialysis Center) on M, W, F (Monday, Wednesday, Friday) - Chair time 4 p.m. (Inaccurate chair time)." On 7/30/20 at 3:02 p.m., a telephone interview was conducted with ASM #3, the ADON (Assistant Director of Nursing). When asked the process for reviewing admission orders for a dialysis resident, ASM #3 stated that first the admissions department will call the hospital and verify dialysis schedule, location, times and transportation. ASM #3 then stated that information should also be documented on the	F 698		

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F 698	Continued From page 4	F 698		

hospital discharge summary. ASM #3 then stated that the nurse conducting the admission should also transcribe the dialysis order into the computer system. ASM #3 stated that the hospital usually provided arrangements for the first three dialysis session but that this information should be communicated to the nursing staff either by the hospital discharge instructions or the admissions department. When asked the process if this information was not communicated to the nurses or not on the hospital discharge summary, ASM #3 stated that she would expect the nurse to call and clarify dialysis orders. When asked why Resident #1 went to the ER on 7/27/20 and 7/30/20 rather than the dialysis center, ASM #3 stated that the nurse must not have given report to the oncoming shift. ASM #3 stated that there must have been a breakdown in communication

On 7/31/20 at approximately 11:00 a.m., a telephone interview was conducted with a general floor nurse, LPN (Licensed Practical Nurse) #2. When asked the process for reviewing admission orders on a new admission, LPN #2 stated that she will take d/c hospital orders off the discharge summary from the hospital and enter them into the computer system. LPN #2 stated she will clarify orders with the physician and then fax the orders to the pharmacy. When asked if this was the same for a dialysis order, LPN #2 stated that she will also write the dialysis order on the physician order sheet. When asked the process if there was no clear direction on the location and chair time of a new resident's dialysis on the hospital d/c instructions, LPN #2 stated that contact the facility scheduler to have them set up or find out where the resident is supposed to go. LPN #2 stated that usually the admissions department would already coordinate that

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information. When asked the purpose of a dialysis order, LPN #2 stated that the purpose of the dialysis order is to alert nursing staff exactly on the dialysis schedule, chair time, and location of center. LPN #2 stated that she would also expect to see this information on the resident's care plan. When asked if it was important that the care plan be accurate, LPN #2 stated that it was because it was the guide of care for each particular resident.

On 8/3/20 at approximately 11:31 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON were made aware of the above concerns.

The facility's dialysis policy did not address the above concerns.

1 b. For Resident #1, facility staff failed to provide evidence of ongoing communication with the dialysis center before and after scheduled dialysis appointments.

Review of Resident #1's hospital course summary documented the following: "End Stage Renal Disease on HD (Hemodialysis). Nephrology was following, continue scheduled dialysis TTS (Thursday through Saturday)...Last HD was on 6/25...Patient Instructions: Follow up with nephrology team with Hemodialysis or in 2-3 weeks."

On 7/31/20 at 2:11 p.m., the ADON (Assistant Director of Nursing) provided evidence that she had followed up with Resident #1's dialysis orders on 6/30/20. The following was documented in an email to the scheduler: "...his info is (Name of Dialysis Center), (Dialysis address), Tu, Thurs,

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F 698	Continued From page 6 and Sat, chair time is 7 a.m. and pick up time is 11:30 (pick up time back to facility)." A physician's order was not put into place after this information was obtained on 6/30/20. Review of Resident #1's clinical record failed to evidence that Resident #1 went to his scheduled dialysis appointments on the following days: 7/2/20 (Thursday) and 7/7/20 (Tuesday). Further review of Resident #1's clinical record (July nursing notes) revealed Resident #1's dialysis days changed to M-W-F starting 7/13/20. There was no evidence in Residents #1's clinical record that he attended any dialysis appointments between dates 7/14/20 and 7/24/20. Review of Resident #1's clinical record revealed two dialysis communication forms dated 7/2/20 and 7/29/20. The 7/2/20 form was partially filled out by facility nursing staff. The "Dialysis Communication Forms" documented the following information: "Vital Signs/Current Diet/Fluid Restrictions/New Medications since last dialysis/Medical Problems since last dialysis/Pre dialysis weight/Post dialysis weight/Problems during dialysis/Post Tx (treatment vitals)/Labs drawn/Dietician recommendations/Food/Fluid consumed during dialysis/Medications given during dialysis/additional comments." Review of Resident #1's dialysis care plan dated 6/26/20 and revised 7/22/20 documented the following intervention: "Communicate with dialysis center regarding medication, diet, and lab results.	F 698		

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F 698	Continued From page 7 Coordinate resident's care with dialysis center." On 7/31/20 at approximately 11:00 a.m., a telephone interview was conducted with a general floor nurse, LPN (Licensed Practical Nurse) #2. When asked if anything was sent with a dialysis resident to their appointment, LPN #2 stated that a communication binder should be sent that communicates the resident's status pre and post dialysis. LPN #2 stated it must be completed by the facility nurse and dialysis center. LPN #2 stated that if the resident returns without information from the dialysis center, the nurse was responsible for following up with the dialysis center. On 7/31/20 at approximately 12:40 p.m., a telephone interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 stated that she could not find Resident #1's dialysis communication forms, that his dialysis communication binder went missing we he switched rooms on 7/18/20. ASM #2 stated that staff had to start a new binder. ASM #2 stated that the purpose of the dialysis communication forms was to communicate the resident's status pre and post dialysis. ASM #2 stated that the nurse will fill out the top part of the sheet and the dialysis center will fill out the bottom part. ASM #2 stated that she expected her nurses to call the dialysis facility if communication forms were not completely filled out by the dialysis center. ASM #2 stated that she was still looking for communication forms. On 7/31/20 at 12:49 p.m. ASM #1, the Administrator, was able to provide evidence that Resident #1 went to his scheduled dialysis appointment on 7/7/20. ASM #1 presented a	F 698		

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transport summary that showed Resident #1 was taken to dialysis at 11:00 a.m.

On 7/31/20 at 2:11 p.m., the ADON (Assistant Director of Nursing) was able to present a record that Resident #1 went to dialysis on 7/2/20. The ADON had to call the center to obtain this information. The communication form from dialysis was not in Resident #1's clinical record or dialysis communication binder. The fax confirmation at the top of the communication form was dated 7/31/20 at 1157 (a.m.).

On 7/31/20 at 2:11 p.m., the Director of Nursing (DON-ASM #2) was able to provide evidence that Resident #1 attended the remaining dialysis appointments (dates between 7/14/20 through 7/24/20). This information was not in Resident #1's clinical record or dialysis binder. ASM #2 had to contact the dialysis center to obtain a weight and vital sign log for the corresponding dialysis appointments. The fax confirmation on this log was dated "7/31/20 at 12:42 p.m." Dialysis communication forms still could not be provided for these dates.

On 8/3/20 at approximately 11:31 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON were made aware of the above concerns.

The facility's dialysis policy did not address the above concerns.

1 c. Facility staff failed to notify the physician regarding Resident #1's missed dialysis appointment on 7/11/20.

Review of Resident #1's July nursing notes

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revealed that Resident #1 had missed a dialysis appointment on 7/11/20. The following nursing note was documented: "Called received from (Name of Dialysis) in regards to resident coming to dialysis. Transport did not pick up resident. Chair time (Next chair time) scheduled for Monday 7/13/20 at 530 (AM) Call placed to (Name of Transport), spoke with (Name of personnel) stated that resident was not on pick up today. Per (Name of Personnel) that she would work on transport for Monday and would call back tomorrow to see if transport will be provided. Resident displays no negative effects at this time. Call bell in reach will continue to monitor."

There was no evidence that facility staff notified the physician after his missed dialysis appointment.

There was no evidence in the clinical record that Resident #1 had any changes in condition related to missing one dialysis session.

On 7/31/20 at 10:00 a.m., a telephone interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who worked on 7/11/20 with Resident #1. LPN #1 stated that (Name of transport) did not show up on 7/11/20 to pick up Resident #1 for dialysis. LPN #1 stated that when she called the transport company, they told her that he wasn't on the list for pick up that day. LPN #1 stated that Resident #1 did not go to the ER that day for dialysis. When asked if she had contacted the Resident's physician regarding the missed dialysis appointment, LPN #1 stated that she didn't think she did. LPN #1 stated that she thought she had talked to the nurses at (Name of Dialysis Center) regarding the missed appointment. LPN #1 stated that the nurses will

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usually give an order to send the resident to the ER for treatment but that they did not give an order that time. When asked if she should have contacted Resident #1's physician regarding the missed dialysis appointment, LPN #1 stated that she is normally supposed to.

On 7/31/20 at approximately 11:23 a.m., a telephone interview was conducted with ASM (Administrative Staff Member) #4, the nurse practitioner. ASM #4 stated she would expect nursing staff to alert her if a resident missed a dialysis session. When asked why this was important, ASM #4 stated that she would give further direction such as further monitoring until the next dialysis day or to notify the dialysis center to reschedule. ASM #4 stated depending on the resident's condition, she may have him sent to the ER for dialysis. When asked the complication of missing a dialysis session, ASM #4 stated that a resident may become more confused, build up fluid (edema), BP (blood pressure) may spike, hyperkalemia (increase in potassium) etc. ASM #4 stated that she was not made aware of Resident #1 missing a dialysis appointment. ASM #4 stated that the on-call physician may have been made aware."

On 7/31/20 at 1:37 a.m. during a telephone interview with the ADON (Assistant Director of Nursing) (ASM #3), ASM #3 stated that she was not aware of Resident #1 missing a dialysis appointment on 7/11/20. ASM #3 stated that there must have been a breakdown of communication.

On 8/3/20 at 9:42 a.m., a telephone interview was conducted with the receptionist at the transportation company (OSM (Other Staff

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F 698	Continued From page 11 Member) #1). OSM #1 stated that Resident #1 was never scheduled by the facility to take him to dialysis on 7/11/20. OSM #1 stated that during that time they were taking COVID positive residents. OSM #1 stated that they were not his regular transport to dialysis but helped out on 7/13/20 and 7/14/20 and took Resident #1 to dialysis on those days. On 8/3/20 at approximately 11:31 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON were made aware of the above concerns. The facility's dialysis policy did not address the above concerns. Complaint Deficiency.	F 698		