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WESTMINSTER-CANTERBURY ON CHESAPEAKE BAY	**3100 SHORE DRIVE** **VIRGINIA BEACH, VA 23451**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/14/20 through 1/16/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/14/20 through 1/16/20. Three complaints were investigated during survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 108 certified bed facility was 99 at the time of the survey. The survey sample consisted of 32 current resident reviews and 4 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review, and facility document review the facility staff failed to assess resident for self-administration of medication for 1 of 36 residents (Resident #184) in the survey sample. The findings included:	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/06/2020

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.

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The facility staff failed to assess Resident #184 for self-administration of Fluticasone nasal spray. Resident #184 was admitted to the nursing facility on 12/31/19. Diagnoses for Resident #184 included, but not limited to, seasonal allergies, rhinitis and Chronic Obstructive Pulmonary Disease (COPD).

The resident's Minimum Data Set (MDS) assessment was not due.

During the initial tour of the facility on 01/14/20 at approximately 11:29 a.m., a bottle of Fluticasone Proplonate nasal spray 50-mcg was observed at Resident #184's bedside; on her over bed table in direct view. The resident said she used the nasal spray this morning, one spray in each nostril because she has bad allergies.

On 01/15/20 at approximately 9:10 a.m., the Fluticasone Proplonate nasal spray 50-mcg remained at Resident #184's bedside; on her over bed table in direct view. On the same day at approximately 12:30 p.m., the nasal Fluticasone nasal spray remains at bedside.

Review of the Physician Order Sheet and Medication Administration Record (MAR) for January 2020 starting on 12/31/19, read: Fluticasone Proplonate nasal spray 50-mcg - 1 spray in each nostril as needed one time daily.

On 01/15/20 at approximately 12:35 p.m., License Practical Nurse (LPN) #1 went to Resident #184's room. The LPN went into Resident #184's room while the surveyor remained outside the resident's door. The LPN came out of Resident #184's room with the Fluticasone Proplonate nasal spray 50-mcg. The

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nurse was asked, if Resident #184 had an order to self-administer medications, she replied, "No." The surveyor asked, "What is the facility's policy for a resident to self-administer medications." The LPN stated, "The resident needs to be evaluated and the physician must be notified before a resident is allowed to self-administer medications." The LPN stated, "(Resident #184) and her family need to be educated about bring medications being brought in for (Resident#184) to self-administer."

A briefing was held with the Administrator, Director of Nursing (DON) and Cooperate staff on 01/16/20 at approximately 3:15 p.m. The DON said Resident #184 should have been assessed, if the resident passes the self-administration assessment than an order is obtained to leave at bedside.

The facility's policy: Self-Administered Medications and Treatments (Last revised date - 12/2012).
-Standard: Self-administered medications and treatments must be carefully monitored and recorded in the Medication Administration Record (MAR) and Treatment Record (TAR).

-Policy: Self-administration of medications or treatments by residents is permitted by the physician order that includes dosage, route, and any special instructions.

Procedures include but not limited to...
-The head nurse manager or team leader assesses resident competency to self-administer.
-A decision to permit self-administration is made in concert with the resident.
-Obtain an order from physician. Record on

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F 554	Continued From page 3 MAR. -Explain procedure to resident. Definitions: Fluticasone Proplonate is used to relieve hay fever, and other allergy symptoms, or nonallergic rhinitis, it is usually sprayed in each nostril once daily (https://medlineplus.gov/druginfo/meds/a695002.html).	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		

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F 578	Continued From page 4 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and facility documentation review, the facility staff failed to ensure 3 of 36 residents (#184, #185, and #43), in the survey sample were given the opportunity to formulate an advance directive The findings included: 1. Resident #184 was admitted to the nursing facility on 12/31/19. Diagnoses for Resident #184 included but not limited to, Transient cerebral ischemia attack (mini-stroke) and Heart Failure. Review of the clinical record revealed that there were no advance directive for Resident #184. Review of Resident #184's Physician Order Sheet (POS) for January 2020 revealed the following order: Full Code starting on 12/31/19. On 01/15/20 at approximately 4:18 p.m., an interview was conducted with the Admissions Director who said an Advanced Directive should	F 578		

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have been completed upon admission. She said an audit was started last week because the Advanced Directive were not being done. The Admissions Director said she was not sure why Resident #184's advanced directive was not completed.

On 01/16/20, the following document titled: Advanced Directives/Medical Treatment Decisions with an issue date of 01/15/20 was received. The document contained the following information:
-Organ Donation
-Full Code
-Other Advanced Directives type (life support for organ donation).
-Signed and dated by the resident and Admission Director on 01/20/20.

A briefing was held with the Administrator, Director of Nursing and Cooperate on 01/16/20 at approximately 3:15 p.m. The facility did not present any further information about the findings.

2. Resident #185 was admitted to the nursing facility on 01/07/20. Diagnoses for Resident #185 included but not limited to, Chronic Obstructive Pulmonary Disease (COPD).

Review of the clinical record revealed that there were no advance directive for Resident #185.

Review of Resident #185's Physician Order Sheet (POS) for January 2020 revealed the following order: Full Code starting on 01/07/20.

On 01/15/20 at approximately 4:18 p.m., an interview was conducted with the Admissions Director who said an Advanced Directive should

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have been completed upon admission. She said an audit was started last week because the Advanced Directive were not being done. The Admissions Director said she was not sure why Resident #185's advanced directive was not completed.

On 01/16/20, the surveyor was given the following document titled: Advanced Directives/Medical Treatment Decisions with an issue date of 01/15/20. The document contained the following information:
-I do not choose to formulate or issue any Advanced Directives at this time.
-Signed and dated the signed by the resident, legal representative and the Lead Social Worker.

A briefing was held with the Administrator, Director of Nursing and Cooperate on 01/16/20 at approximately 3:15 p.m. The facility did not present any further information about the findings.
3. Resident #43 was admitted to the facility on 09/03/2019. Diagnosis included but were not limited to, Respiratory Failure and Heart Failure. Resident #43's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/12/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. .

On 01/15/2020 a copy of Resident #43's Advance Directive was requested.

On 01/15/2020 at 3:20 p.m., an interview was conducted with the Quality Improvement and Compliance Manager, when she was asked the process for reviewing Advance Directives with residents, new admissions, the Quality Improvement and Compliance Manager stated,

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F 578	Continued From page 7 "The process we follow is admissions reviews resident rights with the resident and reviews how to formulate advance directives with the resident." The Surveyor requested evidence of what information the Admissions Director reviewed with the resident. An interview was conducted with Other Staff Member (OSM) #2, Admissions Director, on 01/15/2019 at 4:15 p.m. when asked to explain the process concerning Advanced Directives, the Admissions Director stated, "We review the facility agreement with the resident and review resident rights, the right to request, refuse and / or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. If the resident has an advance directive we scan it into the medical record. If the resident does not have an advance directive we ask them if they would like to formulate an advance directive and speak with the Social Worker." When the Admissions Director was asked where it is documented that they review advance directives and ask if they would like to formulate an Advance Directive, the Admissions Director stated, "We do not document anywhere. We just have the resident sign the Signature Form." When the Admissions Director was asked if the residents refusal to formulate an Advance Directive should have been documented, the Admissions Director stated, "Yes I think they should have documented if the resident refused to formulate an Advance Directive." The Admissions Director stated, "An Acknowledgement of Receipt form was just implemented after an audit was done this past Thursday." On 01/15/2020 the Surveyor received copy of	F 578		

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F 578	Continued From page 8 Resident #43's Durable Do Not Resuscitate Order dated 07/31/2019 and copy of The Hoy Center Westminister Canterbury on Chesapeake Bay Signature Form. The facility was unable to provide evidence that the facility had offered the resident an opportunity to formulate an advance directive. The Administrator and Director of Nursing was made aware of the finding during briefing on 01/16/2020 at approximately 6:45 p.m. No further information was provided.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

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designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to report an injury of unknown origin that resulted in a serious bodily injury (right hip fracture) on 07/11/19, within 2 hours to the State Survey Agency, for 1 of 36 residents (Resident #183) in the survey sample.

The findings included:

Resident #183 was admitted to the nursing facility on 07/10/19 with a diagnosis of left hip fracture. Resident #183 was discharged to the (local hospital) on 07/11/19 with an admitting diagnosis of right hip fracture.

The resident's Minimum Data Set (MDS) assessment was not due at the time of discharge.

Review of Resident #183's Nursing Admission Assessment Comprehensive completed on 07/10/19 included but not limited to:
-Cognitive patterns/mental health: short-term memory problem, no issues with long term-memory problem.
-Transfer ability: 2 assist chair bound.
-Toilet use: assist with toileting.

A phone interview was conducted with Certified Nursing Assistant (CNA) #2 on 01/15/20 at approximately 12:17 p.m., who stated, "I'm sorry but I really don't remember Resident #183." CNA

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#2 was assigned to Resident #183 on 07/11/19, the night Resident #183 stated she had fallen.

A statement written by CNA #2 on 07/11/19 included but not limited to: transferred Resident #183 to her wheel chair with the assistance from (Registered Nurse-RN #3). Resident #183 sat quietly by the doorway watching TV until the end of the shift.

A phone call was placed to Registered Nurse (RN) #3 on 01/15/20 at approximately 12:08 p.m. The RN was assigned to Resident #183 on 07/10/19-07/11/19 (7 p.m.-7 a.m.); a message was left, RN #3 never called back.

A statement written by RN #3 on 07/11/19 was reviewed and included but not limited to: Resident #183 wanted to swing her legs in out of bed, stating she did not belong here. Resident #183 complained of pain saying, I cannot move my leg. The RN explained that swinging her legs back and forth trying to get out of bed would only cause more pain; resident was non-complaint. The RN said she and the CNA assisted Resident #183 using a gait belt into wheel chair. Chair alarm placed and working properly.

Review of Resident #183's clinical notes were reviewed and included but not limited to:
-07/11/19, revealed the following information: "Therapy in to evaluate, per therapy Resident #183 was complaining of right hip pain and unable to move/lift right leg on evaluation with severe pain 10/10 on pain scale. Therapy was concerned."

-07/11/19, included but not limited to: physician in to see Resident #183 with new orders to get an

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x-ray of right hip and EKG, hold therapy for today and to send Resident #183 if x-ray shows right hip fracture.

Review of Physical Therapy note dated 07/11/19 read in part...
-Pain Assessment: Resident #183 confused but stating she fell on right hip last night or this morning. No report per nursing.

Review of Resident #183's Radiology Report dated 07/11/19 included the following:
-Examination: Hip UNI with or without pelvis - 1 view, right.
-Results: There is an acute femoral next fracture with moderate displacement.

Review of Resident #183's clinical note dated 07/12/19 included the following: Resident #183 admitted to the hospital for right hip fracture.

A briefing was held with the Administrator, Director of Nursing (DON) and Cooperate staff on 01/16/20 at approximately 3:15 p.m. It was discussed that Resident #183 had an x-ray done on 07/11/19, which revealed a right hip fracture, first identified while at the nursing facility. The Administrator was asked if Resident #183's right hip fracture; a fracture of unknown origin; the Administrator replied, "Yes." The Administrator was asked if a Facility Reported Incident (FRI) submitted to the State Survey Agency; the Administrator stated, "No."

The facility's policy titled: Abuse Prevention, Detection, Investigation and Reporting (Revised 04/2017) included:
-Reporting
a. The organization will maintain systems to

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ensure that all alleged violations involving abuse neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident properly, are reported immediately, but not later than 2 hours after the allegation is made, if the events causes allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that case the allegation do not involve abuse and do not result in serious body injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

b. Each covered individual/mandated reporter shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or crime, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

F 622 SS=D | Transfer and Discharge Requirements | F 622
CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the

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services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care

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F 622	Continued From page 14 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on a closed record review and staff interviews the facility failed to ensure that care plan goals were sent upon discharge to the hospital for 1 of 36 Residents in the survey	F 622		

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sample, Resident #85.

The findings included:

Resident #85 was admitted to the facility on 9/26/19 with diagnoses to include but not limited to Major Depressive Disorder and Left Acetabulum Fracture.

The most recent comprehensive Minimum Data Set was an Admission Assessment with and a Assessment Reference Date (ARD) of 10/7/19. The Brief Interview for Mental Status (BIMS) was an 8 out of a possible 15 which indicated Resident #85 was moderately cognitively impaired. Resident #85 also has a Discharge/Return Not Anticipated Assessment with an ARD date of 10/17/19 that was reviewed. Under Section A2100 Discharge Status the resident was coded: Acute Hospital.

Resident #85's Comprehensive Care Plan was reviewed and is documented in part, as follows:

Problems: Fall with fracture, Risk for bleeding secondary to anticoagulant use, Diagnosis of depression, Risk for pain, Needs assist for mobility and activities and mobility (toe touch weight-bearing to left lower extremity), Alteration in cardiac output due to hypertension and atrial fibrillation, Risk for aspiration/dysphagia, and Malnutrition.

Resident #85's Clinical Notes were reviewed and are documented in part, as follows:

10/17/19 at 23:47 (11:47) P.M.: Received call from laboratory with critical results: K+ (potassium) 7.1. Called placed to Name (Medical

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F 622	Continued From page 16 Doctor) orders fro Kayexalate 30gm(grams) STAT and send to hospital via 911: Resident lethargic, follows commands, VSS (vital signs stable), NAD (no apparent distress). Son at bedside, this nurse explained orders received and next steps to be taken. Son voices understanding. Paramedics arrived, report given, departed with resident. On 1/16/20 at approximately 11:30 A.M. and interview was conducted with the Administrator regarding Resident #85's discharge on 10/17/19 to the hospital and if care plan goals were sent upon discharge. The Administrator stated, "I don't have any documentation to support the care plan goals were sent with the resident. We have a new process that we are beginning and will include that." There was no facility policy for care plan goals to be sent with the resident upon discharge to the hospital per the Administrator. Prior to exit no further information was shared by the facility staff.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		

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F 625	Continued From page 17 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on a closed record review and staff interviews the facility staff failed to ensure that a bed-hold notice was sent upon discharge to the hospital for 1 of 36 Resident's in the survey sample, Resident #85. The findings included: Resident #85 was admitted to the facility on 9/26/19 with diagnoses to include but not limited to Major Depressive Disorder and Left Acetabulum Fracture. The most recent comprehensive Minimum Data Set was an Admission Assessment with and a Assessment Reference Date (ARD) of 10/7/19. The Brief Interview for Mental Status (BIMS) was an 8 out of a possible 15 which indicated Resident #85 was moderately cognitively impaired. Resident #85 also has a Discharge/Return Not Anticipated Assessment	F 625		

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F 625	Continued From page 18 with an ARD date of 10/17/19 that was reviewed. Under Section A2100 Discharge Status the resident was coded: Acute Hospital. Resident #85's Physician Orders were reviewed and are documented in part, as follows: 10/17/19: Send to ER (emergency room) via 911. On 1/16/20 at approximately 11:30 A.M. and interview was conducted with the Administrator regarding Resident #85's discharge on 10/17/19 to the hospital and if a bed-hold notice was sent upon discharge. The Administrator stated, "We called the family the following day and offered the bed-hold, but no, we did not send a bed-hold notice when the Resident was discharged." There was no documented evidence of the bed-hold notice. There was no facility policy for bed-hold notices to be sent with the resident upon discharge to the hospital per the Administrator. Prior to exit no further information was shared by facility staff.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review the facility staff failed to ensure that the assessment accurately reflected one of 36 residents in the survey sample (Resident #20). The findings included:	F 641		

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Resident #20 was originally admitted to the facility on 03/09/2018 with a readmission date of 05/10/2019. Diagnoses included but were not limited to, Parkinson's Disease and Unspecified Dementia With Behavioral Disturbance. Resident #20's current Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date of 10/27/2019. Resident #20 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #20 as requiring extensive assistance of 1 with personal hygiene, extensive assistance of 2 with bed mobility, transfer, dressing and toilet use, total dependence of 1 with eating and total dependence of 2 with bathing.

On 01/16/2020 review of Resident #20's clinical record revealed that Section G0400 - "Functional Limitation in Range of Motion" on the Quarterly Assessment was coded with a coding of "2" impairment on both sides as A. Upper extremity and B. Lower extremity.

On 01/16/2019 at 1:00 p.m., Resident #20 was observed in a wheelchair in his room and the nurse in his room provide verbal cues to the resident to lift his arms and straighten them. Resident #20 complied. The nurse provided verbal cues to Resident #20 to straighten his legs. Resident #20 complied with assistance from nurse. No limitations noted in upper extremities or left lower extremity. Minimal limitation noted in right knee.

An interview was conducted with Registered Nurse (RN) #1, MDS Coordinator, on 01/16/2020

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F 641	Continued From page 20 at approximately 1:30 p.m. When asked if the "Range of Motion" section of the MDS dated 10/27/2019 was correct, RN #1 stated, "I will check and get back with you." On 01/16/2020 at approximately 2:05 p.m., RN #1 stated, "The MDS dated 10/27/2019 is incorrect but the Nurse Progress Note dated 10/28/2019 is correct." RN #1 provided a copy of the Clinical Note Entry dated 10/28/2019 and the note read as follows: "Per resident interview of 10/28. Has adequate hearing with hearing aides, has highly impaired vision without glasses but able to identify pen. Has no visible teeth. Has adequate ROM (Range of Motion). BIMS 3/15. Denies any pain or SOB (Shortness of Breath)." RN #1 stated, "I can't explain, obviously it is a two (2) and should be a zero (0). I will do a modification." When RN #1 was asked if the MDS dated 10/27/2019 was an inaccurate assessment, RN #1 stated, "Yes it is." RN #1 provided a modified copy of the MDS with Attestation date of completion, 01/16/2020, and a copy of CMS (Centers for Medicare and Medicaid Services) Submission Report on 01/16/2020 at approximately 3:00 p.m. The Administrator and Director of Nursing was informed of the finding at a briefing on 01/16/2020 at approximately 6:45 p.m. The facility did not present any further information about the findings.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 22 Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to develop a comprehensive care plan for two of 36 residents in the survey sample (Residents #22 and #190). The findings included: 1. Resident #22 was admitted to the facility on 8/9/19 with diagnoses that include but were not limited to, chronic obstructive pulmonary disease and pneumonia. Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #22 was coded in Section "O" "Special Equipment" as receiving oxygen therapy. On 1/14/20 at 11:30 a.m. and at 12:46 p.m., observations were made of Resident #22. Resident #22 was sitting in her recliner with her nasal cannula in place receiving 2 liters of oxygen. Review of Resident #22's January 2020 POS (physician order summary) revealed the following order dated 8/9/19 (admission order): "Continuous oxygen at HS (at night) as ordered (specify in notes)...notes 02@(at) 2 L (liters)/min (minute) via nasal cannula at HS." Resident #22's admission assessment dated 8/9/19 documented that Resident #22 was receiving oxygen therapy upon admission to the facility.	F 656		

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Review of Resident #22's comprehensive care plan dated 8/10/19, failed to evidence a care plan for oxygen therapy or a respiratory care plan.

On 1/16/2020 an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #22's nurse. When asked if Resident #22 was on oxygen, LPN #2 stated that she was. LPN #2 stated that Resident #22 was admitted with oxygen to wear at night. LPN #2 stated that Resident #22 "desated" (oxygen desaturated) at night. When asked the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to outline the plan of care to all clinical staff. When asked if she would expect to see the comprehensive care plan to reflect the resident's use of oxygen, LPN #2 stated that she would. When asked the typical nursing interventions for a resident on oxygen, LPN #2 stated that the care plan should address checking pulse oximetry, oxygen safety, changing tubing etc. LPN #2 confirmed that she could not find a care plan for oxygen on Resident #22's comprehensive care plan.

On 1/16/2020 at 3:45 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "Comprehensive Person Centered Care Planning," documents in part, the following: "The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs as identified throughout the

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F 656	Continued From page 24 comprehensive Resident Assessment Instrument (RAI) process...each residents comprehensive care plan will describe the following: a. Services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well being." 2. The facility staff failed to develop a care plan for Resident #190 who was on isolation precautions due to a diagnosis of Clostridium Difficile Colitis (C-Diff). Resident #109 was admitted to the nursing facility on 01/02/20. Diagnosis included but not limited to, Entercolitis due to C-Diff. The resident's Minimum Data Set (MDS) assessment was not due. The review of Resident #190's comprehensive care plan did not include a care plan for the diagnosis of C-Diff. An interview was conducted with the Director of Nursing (DON) on 01/15/20 at approximately 4:35 p.m. The DON reviewed Resident #190's care plan then stated, "Yes, Resident #190 should have a C-Diff care plan." On 01/16/20, a C-Diff care plan was given to the surveyor that was created on 01/15/20, but only after, it was requested. The review of the C-Diff care plan included but not limited to the following information: Resident #190 was admitted with recurrent C-Diff-antibiotic infection. Goal: isolation for C-Diff, monitor bowel frequency and consistency, transmission precautions as indicated per Infectious Diseases and GI until fecal transplant, provide teaching to resident, family and staff related to infection, good handwashing, precautions every shift as needed	F 656		

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F 656	Continued From page 25 and resident on contact transmission based precautions for diagnosis of C-Diff. A briefing was held with the Administrator, Director of Nursing and Cooperate on 01/16/20 at approximately 3:15 p.m. The facility did not present any further information about the findings. The facility's policy: Life Care-Comprehensive Person Centered Care Planning (Revision 04/2020). Policy: A Preliminary (interim) care plan to meet the resident's immediate needs shall be developed for each resident with (48) hours of admission. Definitions: -C-Diff is a bacterium that causes diarrhea and colitis - an inflammation of the colon (https://www.cdc.gov).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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WESTMINSTER-CANTERBURY ON CHESAPEAKE BAY	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 657	Continued From page 26	F 657		

the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure the comprehensive care plan was revised based on changing goals, preferences and needs of the resident for 2 of 36 residents in the survey sample, Resident # 38, and #22.

The findings included:

1. For Resident #38, the facility staff failed to revise the care plan when the residents Stage 4 pressure area was healed on the left heel.

Resident #38 was admitted to the facility on 08/29/2019. Diagnoses included but were not limited to, Pressure Ulcer of Left Heel, Stage 4 and Paroxysmal Atrial Fibrillation. Resident #38's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/21/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27 On 01/16/2020 at approximately 6:00 p.m., the Wound Physicians Wound Evaluation and Management Summary for Resident #38 was reviewed and revealed the following: "Summarized Wound Care Assessment And Individualized Treatment Plan - (Site 1) Stage 4 Pressure Wound Of The Left heel (Resolved on 10/14/2019). On 01/16/2020 at approximately 6:15 p.m., review of Resident #38's Comprehensive Care Plan with an effective date of 08/31/2019 - Present revealed the following problems and goals and are documented in part, as follows: "At Risk For Falls R/T (Related To) decreased mobility r/t non-healing L (Left) heel Stage 4 pressure ulcer, DM (Diabetes Mellitus) 2, OP, CHF (Congestive Heart Failure), CAD (Coronary Heart Disease) and use of antidepressants. STATUS: Active (Current) Goals: Resident will transfer safely with assistance. STATUS: Active (Current) GOAL DATE: 3/4/2020"; "Self care deficit R/T advanced age, decreased mobility r/t nonhealing L heel Stage 4, DM 2, CHF, and HX (History) of CAD. STATUS: Active (Current) Goals: Will safely perform to maximal ability self care activities. STATUS:Active (Current) GOAL DATE: 3/4/2020"; "Risk for alteration in skin integrity R/T Stage 4 left heel; 09/3/19. Currently using air mattress and Prevalon boots. STATUS: Active (Current). Goals: (Resident Name) alteration area will resolve without complications and no other areas will occur. STATUS:Active (Current) GOAL Date: 3/4/2020"; "Pain R/T chronic pain and nonhealing L heel Stage 4 pressure ulcer. STATUS: Active (Current) Goals: Resident will state / demonstrate relief or reduction in pain intensity after receiving interventions. STATUS: Active (Current) GOAL	F 657		

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DATE: 3/4/2020."

An interview was conducted with the Director of Nursing (DON) on 01/16/2020 at 6:30 p.m., when asked if Resident #38 currently had a wound on her left heel, the DON stated, "No, it is healed." When the DON was asked if the care plan should have been updated that the Stage 4 wound is healed on the left heel, the DON stated, "Yes." When the DON was asked what her expectations are of the nurses and documenting in the care plans, the DON stated, "I expect that they update the care plans."

The Administrator and Director of Nursing was informed of the finding during a briefing on 01/16/2020 at approximately 6:45 p.m. The facility did not present any further information about the finding.
2. For Resident #22, facility staff failed to revise the care plan while she was receiving antibiotics for her recent diagnosis of pneumonia.

Resident #22 was admitted to the facility on 8/9/19 with diagnoses that include but were not limited to chronic obstructive pulmonary disease and pneumonia. Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 1/14/20 at 12:46 p.m., an interview was conducted with Resident #22. Resident #22 was sitting in he recliner with oxygen in place via nasal cannula at 2 liters/minute. Resident #22 stated that she had been sick for almost a week with

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pneumonia. Resident #22 stated that she was still receiving a "shot" for her pneumonia.

Review of Resident #22's clinical record revealed that a chest x-ray had been performed on 1/7/2020. The following result documented in part: "There is slight pneumonia involving the right lower lobe..."

Review of Resident #22's January 2020 POS (physician order summary) documented the following antibiotic orders for treatment of Resident #22's pneumonia:

"Rocephin (1) 1 gram solution for injection (2 gm) Vial intramusclar Hour of sleep for seven days. Starting 1/8/20 - Pneumonia."
"Azithromycin (2) 500 mg (milligrams) tablet (500 mg) Tablet Oral for One day starting 1/9/20 - Pneumonia
"Azithromycin 250 mg for four days starting 1/10/20 - Pneumonia."

Review of Resident #22's comprehensive care plan dated 8/10/19 with revisions; failed to evidence a care plan reflecting Resident #22's pneumonia and antibiotic therapy.

Review of Resident #22's January 2020 MAR (medication administration record) revealed Resident #22 was to receive her last dose of Rocephin on 1/14/20 night shift.

On 1/16/20 at 10:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #22's nurse. When asked who was responsible for revising the care plan, LPN #2 stated that the interdisciplinary team updated the care plan as things change with the residents

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care. LPN #2 stated that floor nurses can also revise the care plan. When asked the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to outline the plan of care to all clinical staff. When asked if a resident has a new infection and placed on antibiotics, if the care plan should be revised to reflect the new infection, LPN #2 stated that she would expect the care plan to be revised. LPN #2 confirmed that she could not find a current care plan for Resident #22's infection. LPN #2 stated that maybe Resident #22's pneumonia care plan had been resolved because her last dose of antibiotics was the night of the 14th (1/14/2020). This writer made LPN #2 aware that on 1/14/20 a care plan could not be found.

On 1/16/2020 at 3:45 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "Comprehensive Person Centered Care Plan" documents in part the following: "The Care Planning/Interdisciplinary team is responsible for the review and updating of care plans:
a. When requested by the resident/resident representative.
b. When there has been a significant change in the resident's condition;
c. When the desired outcome is not met;
d. When the resident has been readmitted to the facility from the hospital stay; and
e. At least quarterly and after each OBRA MDS assessment."

F 658 SS=D Services Provided Meet Professional Standards F 658

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F 658	Continued From page 31 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 staff interview and clinical record review the facility staff failed to meet professional standards of practice by incorrectly transcribing a medication order for Lasix (a diuretic) for one of 36 residents in the survey sample (Resident #41). The findings included: Resident #41 was originally admitted to the facility on 07/14/2017. Diagnoses included but were not limited to, Acute on Chronic Systolic (Congestive) Heart Failure, Chronic Atrial Fibrillation and Unspecified Dementia without Behavioral Disturbance. Resident #41's Annual Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/24/2019 was coded with a BIMS (Brief Interview for Mental Status) of 06 indicating severe cognitive impairment. On 01/15/2020 a copy of a Medication Error/Incident Report dated 02/05/2019 was obtained and reviewed. Review of report revealed and was documented in part, the following: "Description of incident: Lasix 60 mg. (Milligram) Q (Every) a.m. X (Times) 2 (Two) days with BNP, CBC (Complete Blood Count), BMP (Basic Metabolic Panel) 2/7/18 was written on M.D. (Medical Doctor) communication log -	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 32 next to (Resident Name) but in communication with provider orders were meant for resident above (another Resident's Name)............" An interview was conducted with the Medical Director on 01/15/2020 at 5:20 p.m. and he stated, "The PA (Physician Assistant) wrote the order for Lasix 60 mg on the communication log for another resident." The Medical Director stated, "I was made aware of of the med error on 02/05/2019 and I ordered to hold the evening dose and the next a.m. dose, each 20 mg doses of Lasix." The Medical Director stated, "(Resident Name) already had an order for Lasix 20 mg twice a day." The Medical Director also stated, "(Resident Name) was monitored for hypotension and no problems were noted. (Resident Name) labs - BUN went from 25 on 01/21/2019 to 23 on 2/15/2019 which was better - not significant but still better." When the Medical Director was asked if Resident #41 had any side effects from receiving the extra 40 mg. of Lasix on 02/05/2019, the Medical Director stated, "No, none what so ever." On 01/16/2020 review of Resident #41's February 2019 Medication Administration Record revealed the following: Order for - Lasix 20 mg tablet (40 mg) Tablet Oral One Time Daily for Two Days Starting 02/05/2019 and an Order for - Lasix 20 mg tablet (20 mg) Tablet Oral Two Times Daily Starting 01/16/2019 - Nurse initialed boxes on 02/05/2019 indicating medications were administered as ordered. The nurse who transcribed the order no longer worked at the facility. On 01/16/2020, the facility policy titled - Medication Management Plan was reviewed and	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 33 included: Purpose: To ensure that the right resident receives the right drug, in the right dose and dosage form, at the right time, via the correct rout, and to ensure the resident has the right response to the medication. To ensure that all staff responsible for medication administration are qualified and fully informed of all policies and procedures in medication management and the pharmacy operating procedures. The Administrator and Director of Nursing was made aware of the finding during briefing on 01/16/2020 at approximately 6:45 p.m. No further information was provided. Complaint Deficiency.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, it was determined that facility staff failed to follow a physician's order for oxygen for one of 36 residents in the survey sample, Resident #22.	F 695		

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The findings included:

Resident #22 was admitted to the facility on 8/9/19 with diagnoses that include but were not limited to chronic obstructive pulmonary disease and pneumonia. Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #22 was coded in Section "O" "Special Equipment" as receiving oxygen therapy.

On 1/14/20 at 11:30 a.m. and at 12:46 p.m., an observation was made of Resident #22. Resident #22 was sitting in her recliner with her nasal cannula in place receiving 2 liters of oxygen. Resident #22 had stated that she was not sure why she needed her oxygen on; that she usually received oxygen at night. Resident #22 stated that staff tell her she needs it (oxygen). Resident #22 could not elaborate on who told her to wear her oxygen during the day.

Review of Resident #22's January 2020 POS (physician order summary) revealed the following order dated 8/9/19 (admission order): "Continuous oxygen at HS (at night) as ordered (specify in notes)...notes 02@(at) 2 L (liters)/min (minute) via nasal cannula at HS."

On 1/16/20 at 10:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #22's nurse. When asked if Resident #22 needed oxygen, LPN #2 stated that Resident #22 had orders to wear 2 liters of oxygen at night. LPN #2 stated that Resident

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F 695	Continued From page 35 #22's oxygen desaturated at night. LPN #2 stated that her oxygen sometimes dropped below 90 percent on room air while sleeping. LPN #2 also stated that Resident #22 had prn (as needed) orders for oxygen. When asked if she could pull up the "as needed" orders, LPN #2 looked through Resident #22's clinical record and stated, "I don't even see one." LPN #2 stated that Resident #22 should just be wearing oxygen at night if there are no active orders for PRN. When told LPN #2 about the above observations, LPN #2 stated that her oxygen should not have been in place during the day. On 1/16/2020 at 3:45 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Oxygen Therapy," documents in part, the following: "Oxygen administration requires a physician order that includes: 1. Medical Reason or Diagnosis 2. Flow Rate 3. Frequency of 02 saturation levels 4. Continuous or PRN administration."	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 36 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff incorrectly transcribed a medication order for one of 36 residents in the survey sample (Resident #41), which resulted in the resident receiving an unnecessary dose of Lasix (a diuretic). The findings included: Resident #41 was originally admitted to the facility on 07/14/2017. Diagnoses included but were not limited to, Acute on Chronic Systolic (Congestive) Heart Failure, Chronic Atrial Fibrillation and Unspecified Dementia without Behavioral Disturbance. Resident #41's Annual Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/24/2019 was coded with a BIMS (Brief Interview for Mental Status) of 06 indicating severe cognitive impairment. On 01/15/2020 a copy of a Medication Error/Incident Report dated 02/05/2019 was obtained and reviewed. Review of report	F 757	Past noncompliance: no plan of correction required.	

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F 757	Continued From page 37 revealed and was documented in part, the following: "Description of incident: Lasix 60 mg. (Milligram) Q (Every) a.m. X (Times) 2 (Two) days with BNP, CBC (Complete Blood Count), BMP (Basic Metabolic Panel) 2/7/18 was written on M.D. (Medical Doctor) communication log - next to (Resident Name) but in communication with provider orders were meant for resident above (another Resident's Name)............" An interview was conducted with the Medical Director on 01/15/2020 at 5:20 p.m. and he stated, "The PA (Physician Assistant) wrote the order for Lasix 60 mg on the communication log for another resident." The Medical Director stated, "I was made aware of of the med error on 02/05/2019 and I ordered to hold the evening dose and the next a.m. dose, each 20 mg doses of Lasix." The Medical Director stated, "(Resident Name) already had an order for Lasix 20 mg twice a day." The Medical Director also stated, "(Resident Name) was monitored for hypotension and no problems were noted. (Resident Name) labs - BUN went from 25 on 01/21/2019 to 23 on 2/15/2019 which was better - not significant but still better." When the Medical Director was asked if Resident #41 had any side effects from receiving the extra 40 mg. of Lasix on 02/05/2019, the Medical Director stated, "No, none what so ever." On 01/16/2020 review of Resident #41's February 2019 Medication Administration Record revealed the following: Order for - Lasix 20 mg tablet (40 mg) Tablet Oral One Time Daily for Two Days Starting 02/05/2019 and an Order for - Lasix 20 mg tablet (20 mg) Tablet Oral Two Times Daily Starting 01/16/2019 - Nurse initialed boxes on 02/05/2019 indicating medications were	F 757		

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administered as ordered. The nurse who transcribed the order no longer worked at the facility.

On 01/16/2020, the facility policy titled - Medication Management Plan was reviewed and included:

Purpose: To ensure that the right resident receives the right drug, in the right dose and dosage form, at the right time, via the correct rout, and to ensure the resident has the right response to the medication. To ensure that all staff responsible for medication administration are qualified and fully informed of all policies and procedures in medication management and the pharmacy operating procedures.

The Administrator and Director of Nursing was made aware of the finding during briefing on 01/16/2020 at approximately 6:45 p.m. No further information was provided.

Complaint Deficiency.

F 761 SS=D — Label/Store Drugs and Biologicals (F 761)
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING ______ B. WING ______	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER-CANTERBURY ON CHESAPEAKE BAY	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 761	Continued From page 39	F 761		

Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to ensure one multi dose vial of Tuberculin Purified Solution was properly dated when opened on one of four nursing units, Stone Rehab Unit A.

The findings included:

On 01/16/2020 at approximately 10:30 a.m., an inspection of the refrigerator in the Medication Storage Room on Stone Rehab Unit A with Licensed Practical Nurse (LPN) #1 was conducted. A plastic bag labeled "Aplisol 10 Test (Mantoux), Stock Supply, Store in Refrigerator, Date Opened (not dated) Do Not Use 30 Days After Above Date. QTY (Quaintly) 5" was observed. Inside of the plastic bag were 2 multidose vials of Tuberculin Purified Solution 5TU / 0.1 ml, 1 unopened vial and 1 opened vial which was not dated when it was opened. When LPN #1 was asked if the vial should be dated when opened, LPN #1 stated, "Yes, everything gets dated because after 30 days it gets thrown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING ______ B. WING ______	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER-CANTERBURY ON CHESAPEAKE BAY	**3100 SHORE DRIVE** **VIRGINIA BEACH, VA 23451**

(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 761	Continued From page 40 out. It's not dated." LPN #1 discarded the opened, undated vial of solution. The Administrator and Director of Nursing were made aware of the finding during a briefing on 01/16/2020 at approximately 6:45 p.m. No further information was provided.	F 761		