PRINTED: 08/31/2021 FORM APPROVED

RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
	495309	B. WING_			08/19/2021
PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
LUENTTH MODEOLK			82	7 NORVIEW AVENUE	
THEALTH NORFOLK			NC	ORFOLK, VA 23509	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	ζ ,	(EACH CORRECTIVE ACTION SHOU	D BE COMPLETION
INITIAL COMMENTS	3	FO	000		
complaint survey was 8/19/21. Four complaint survey: VA000 with deficiencies. VA0 with deficiencies. VA0 with deficiencies. Cor compliance with 42 C Term Care requirement of the survey consisted of 8 current (Residents #1 through reviews (Resident #9 Notify of Changes (In	s conducted 8/17/21 through aints were investigated 052777 was substantiated 00050417 was substantiated 0005114 was substantiated 00049709 was substantiated rections are required for FR Part 483 Federal Long ants.  I certified bed facility was 44 yey. The survey sample to resident reviews and 3 closed record (through #11).  Ijury/Decline/Room, etc.)	F 5	80		
(i) A facility must imm consult with the residual consistent with his or representative(s) when (A) An accident involve results in injury and his physician intervention (B) A significant changemental, or psychosocideterioration in health status in either life-thrical complications) (C) A need to alter treatment due to advect commence a new form	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ring the resident which as the potential for requiring ent; ge in the resident's physical, ial status (that is, a eatening conditions or eatening conditions or estimate is a state of the potential form of erse consequences, or to m of treatment); or		2.	was given to RP on 9-9-2021. No COC on PICC line bleeding on to #1 was given to NP on 9-9-2021. missed medications on listed dat was given to NP on 9-9-2021. No medications on listed date for Re with MD on 9-9-2021. Notificati medications on listed date for Re to NP on 9-9-2021.  All residents are at risk when times.	otification regarding bed with Resident Notification of less for Resident #1 otification of missed esident #3 occurred on of missed esident #4 was given lely notifications of
	PROVIDER OR SUPPLIER  HEALTH NORFOLK  SUMMARY ST (EACH DEFICIENC) REGULATORY OR  INITIAL COMMENTS  An unannounced Me complaint survey was 8/19/21. Four comple during survey: VA00 with deficiencies. VA0 with	F CORRECTION IDENTIFICATION NUMBER:  495309 PROVIDER OR SUPPLIER	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495309  B. WING  REQUIDER OR SUPPLIER  HEALTH NORFOLK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  AN unannounced Medicare/Medicaid abbreviated complaint survey was conducted 8/17/21 through 8/19/21. Four complaints were investigated during survey: VA00052777 was substantiated with deficiencies. VA0005417 was substantiated with deficiencies. VA0005114 was substantiated with deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.  The census in this 60 certified bed facility was 44 at the time of the survey. The survey sample consisted of 8 current resident reviews (Residents #1 through #8) and 3 closed record reviews (Resident #9 through #11). 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); (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	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495309  B. WING  STOWN AND TATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  AN UNANANAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  AN UNANANAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  AN UNANANAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  AN UNANANAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  AN UNANANAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  AN UNIT OF TAKE  AN UNIT OF LIBERT OF THE SET OF THE SE	DETECTION OF THE PROVIDER SET OF THE PROVIDER SUMPLIFICATION NUMBER:  A 95309  RECORDER OR SUPPLIER  HEALTH NORFOLK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 8/17/21 through 8/19/21. Four complaints were investigated during survey: VA00052777 was substantiated with deficiencies. VA0005477 was substantiated with deficiencies. VA0005477 was substantiated with deficiencies. VA00049709 was substantiated with deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.  The census in this 60 certified bed facility was 44 at the time of the survey. The survey sample consisted of 8 current resident reviews (Resident #9 through #11). Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)(ii)(15)  \$483.10(g)(14) Notification of Changes. (I) A facility must immediately inform the resident; consistent with is 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 (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or or commence a new form of treat

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

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

Event ID: UCE611

Facility ID: VA0247

PRINTED: 08/31/2021 FORM APPROVED

CENTERS FO	OR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405200	D MANAGE		С
NAME OF BROWN		495309	B. WING		08/19/2021
PELICAN HEAL				STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLETION
resic §48: (ii) V (14) all p is av phys (iii) T resic whee (A) A as s <sub>l</sub> (B) A State (e)(1 (iv) T upda phon	(i) of this section, ertinent information vailable and providuals. The facility must a dent and the residuals in there is A change in room pecified in §483.1 A change in residuals of this section. The facility must residuals in the facility must residuals in the facility must residuals.	ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lso promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or on trights under Federal or as as specified in paragraph ecord and periodically hailing and email) and	F	3. The DON will conduct an audit incidents for the past 30 days to assessment, documentation are completed. Education will be postaff at the facility on Change of incident reporting, notification escalation of adverse events. Reclinical Services will provide ed Nursing Administrative staff on clinical start up, incident report adverse events to the Regional Regional Director of Clinical Services education to Department leader Reports and conducting facility Aids for COC notification will be nursing station	to ensure proper and notifications were provided to licensed of Condition process, and degional Director of ducation to the anthe process for daily ting and escalating Support Team.  Twices will provide ers on Incident Investigations. Job
Admithat it §483 its photocation part, room unde This by: Base clinic and it was continued incide	s a composite dis .5) must disclose a spicial configurations that comprise and must specify changes between \$483.15(c)(9). REQUIREMENT and on resident integral record review, for the course of a determined that fathysician and/or report of unusual occurs.	site distinct part. A facility tinct part (as defined in in its admission agreement on, including the various a the composite distinct the policies that apply to in its different locations is not met as evidenced erview, staff interview, facility document review, complaint investigation, it cility staff failed to notify sponsible party of an urrence for one of 11 sample, Resident #2; of a	5	<ol> <li>DON or designee to audit incide hour nursing reports 3 x per wee completion, accuracy, and notifi condition. Results of audits will I to the QAPI Committee. The QA responsible for the on-going mo- compliance.</li> </ol>	ek x 4 weeks for ication of Change of be reported monthly API committee is

change in resident condition related to a PICC

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		DINSTRUCTION	(X3) (	DATE SURVEY COMPLETED
		495309	B. WING				С
	ROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	EET ADDRESS, CITY, STATE, ZIP COD NORVIEW AVENUE RFOLK, VA 23509	)E	08/19/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 580	line for one of 11 resid	lents, Resident #1; AND lications per physician's sidents in the survey	F	580			
	party when a stranger entered the building ar weapon in the form of Resident #2 was admi 3/13/19 and readmitted diagnoses that include high blood pressure, didepression. Resident #Data Set (MDS) asses assessment with an As (ARD) of 6/8/21. Residing moderately impaired in 11 out of possible 15 of Mental Status Exam (B	ited to the facility on d on 2/15/20 with d but were not limited to ementia, anxiety, and t2's most recent Minimum					
; ; ;	B/22/21 at approximate off the street was able to what appeared to be a Resident #1 stated that when he saw the gentle nursing unit, walk down shank to a resident (Ren wher wheelchair on the	nt #1, another sampled tated that last Sunday on by 6 p.m., a stranger from o enter the building with shank in his hand.  The was in the hallway aman come onto the the hall and hand the sident #2) who was sitting thallway. Resident #1 the who was also a witness					

		MEDICAID SERVICES					IO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		405000				1	С
NAME OF S	200//255 25 24/25	495309	B. WING			30	8/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK			827	NORVIEW AVENUE		
				NO	RFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	Continued From page	2	1				
. 555			F :	580			
	removed the shank fro	om the resident.	ž				i i
	Review of the Facility	Reported Incidents (FRIS)	t.	1			
	revealed no evidence	that this incident has		3			
	occurred.	that this incident has					B
				į			
	On 8/18/21 at 11:15 a	m., an interview was					
	conducted with Certifie	ed Nursing Assistant (CNA)	:				
	#3, the CNA who was	witness to the above	ì				
	incident per Resident	#1. When asked what had					
	occurred on Sunday 8	/22/21, CNA #3 stated that			e g		
	a gentleman was seen	on the nursing unit with	2				
	what appeared to be a	shank in his hand. CNA #3					1
	stated that she witness						1
	the hallway When ask	ing in her wheelchair on ed if the resident and man	i.				
T T	knew each other CNA	#3 stated that she was not					
	sure. CNA #3 stated th	at she immediately					1
	removed the shank fro	m the resident's (Resident					
	#2's) hands. CNA #3 s	tated that the Director of					
	Nursing (DON) was als	o present in the building					1
	and a witness. CNA #3	stated that the DON					
	called the police immed	diately and the man had					
	left the building before	the police had arrived.					
	CNA #3 stated that she	wasn't sure what door the		,			
	man entered from, but	that the front lobby was					
8	witness statement CN	denied having to write a A #3 could not recall the					1
	exact time the man had	Lentered the building					1
	sino silo man nac	choice the building.					
	On 8/18/21 at 1:17 p.m	an interview was					1
	conducted with Adminis	trative Staff Member					- 1
	(ASM) #2, the Director	of Nursing (DON). When					
	asked if a FRI or incide	nt report was completed					- 1
	regarding an incident o	n Sunday, 8/22/21					
l	regarding a man enterir	ng the building with a					
3	weapon, ASM #2 stated	I, "No, because I took care					
(	of it immediately." When	n asked if she figured out					
١	what door the man ente	red from, ASM #2 stated,				7	1

						OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
NAME OF S	200//250 05 04/054	495309	B. WING			08/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			827	NORVIEW AVENUE	
				NOF	RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	IDENTIFICATION NUMBER:  495309  B. WING  PLIER  OLK  MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL NTORY OR LSC IDENTIFYING INFORMATION)  TAG  (X2) MULTIFLE OC.  A. BUILDING  B. WING  PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
E 500	0 " 15					
F 500	Continued From page	4	, F	580		
	"No."					
	0.04004					3
	On 8/18/21 at 2:24 p.n	n., further interview was				*
	conducted with ASM #	2. When asked if she could	i			
	recall the events on 8/	22/21, ASM #2 stated that	i			3
	sne was in the building	working on a medication	i			* *
	stated that at approxim	nad called out. ASM #2	ř.			
	sitting at the nurses et	ation when she saw as				
	unidentified gentleman	enter the purcing unit and				
	walked down the green	hall ASM #2 stated that		1		E S
	she quickly got up to fo	ollow the man as he was				* 1
*	walking really fast. ASI	M #2 stated that she kent				
	asking "Can I help you	with something?" and he				
	continued to walk to the	e therapy department and				<b>)</b>
	then turned around and	d walked quickly to the end	ī			
	of the pink hall. ASM #	2 stated that the man kept				
	saying that he was look	king for someone, that it				
	was personal. ASM #2	stated that (Name of				
	Resident #2) was sitting	g in her wheelchair at the				
	end of the pink hall who	en she introduced herself				
	immediately took the ex	alde was right there and				1
	stated that she was sall	crewdriver away. ASM #2				
	am walking toward tide	water drive " ASM #2				
1	stated the man then left	t the building ASM #2				
	stated that the police ha	ad arrived and she gave a				
9	description to the police	ASM #2 stated that the				
* 1	police told her to just the	row the object away				
,	When asked if this obie	ct was more like a shank				
	and not a screwdriver.	ASM #2 stated, "It was				
,	very pointy and sharp."	When asked the				
,	orientation of Resident	#2, ASM #2 stated that				
ł	Resident #2 was pleasa	intly confused and had				
(	dementia. When asked	if the resident could have				
1	potentially harmed herse	elf with this object, ASM				

	TOT ON WEDICANE &					OMB NO	. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE S COMPL	
		495309	B WING			c	;
NAME OF	PROVIDER OR SUPPLIER	493309	B. WING			08/1	9/2021
TW WILL OF	T NOVIDEN ON SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK				ORVIEW AVENUE		
				NORI	FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	5		-00:			
	#2 stated that it was ta		Ft	80			
		aken out of her hands asn't even in her hands for a				3	
	second. When asked	if Resident #2 could have					
	hurt herself if staff wer	e not present, ASM #2					
	stated, "Possibly if no	one was there." When					
	asked if she had notific	ed Resident #2's	v				
		, ASM #2 stated that she					
	did not because staff h	nad immediately intervened.					
	When asked if Reside	nt #2's RP would probably					
	want to know if someo	ne had handed her mother					
	a weapon, ASM #2 sta				*		
	probably want to be av	vare of that."	3	1			
	On 8/19/21 at 2:49 p.m	n., Administrative Staff					
	Member (ASM) #1, the	Administrator, ASM #2,		3			i
	the DON (Director of N	lursing), ASM #3, the					
	Regional Director of Cl	inical Services, and ASM					
	#5, the corporate nurse above concerns.	e were made aware of the					
	Facility policy titled, "No not address the above	otification of Changes" did					
	information was preser						
	(1) Shank- a makeshift	, knife like weapon. This					
	information was obtained						1
	https://lawenforcementi ontraband-weaponsshi	museum.org/2010/01/20/c vs-and-shanks-a/.		*			
	2. The facility staff failed	d to notify the physician of		w W			
	a change in Resident #	1's condition realated to					
	his peripherally inserted	central catheter (PICC)					
	line on 7/23/21.	or represent V = -1		c v			
	Resident #1 was admitt	ed to the facility on		0			
	7/10/21 and readmitted	on 7/26/21 with				1	
	diagnoses that included						
	unspecified open wound						l

		I				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
	PROVIDER OR SUPPLIER HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509	1 00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
	toe, acute osteomyelit foot, type two diabetes and deep vein thromb extremities. Resident a Data Set (MDS) asses assessment with an as (ARD) of 7/10/21. Res being intact in cognitiv possible 15 on the Brie Status Exam (BIMS). I Section N (Medications Resident #1 was code Treatments and Prograintravenous (IV) medications of Review of Resident #1 (Physician Order Summar following orders:  1) "Zosyn (1) (antibiotic Use 3.375 gram intravening infection for 150 admin discontinued on 8/12/2  2) Heparin Lock Flush (unit/milliliter). Use 1 ur	is of the right ankle and a mellitus, quadraplegia, possis of the lower this most recent Minimum assent was an admission assessment reference date ident #1 was coded as the function scoring 15 out of the function scoring 15 out of the function scoring 15 out of the function scoring antibiotics. It is a receiving antibiotics of in Section O (Special ams) as receiving ations.  It's July 2021 POS mary) documented the second of the seco	F	580		
1	discontinued on 7/23/2- to PRN (as needed) on On 8/17/21 at 10:55 a.r conducted with Resider discussed his concern the beginning of his sta flushing, clamping and r Resident #1 had stated	1. This order was changed 7/23/21.  n., an interview was nt #1. Resident #1 had hat he didn't feel like in y, staff were properly monitoring his PICC line. that on the evening of or nurse; who he could				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		DISTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING _			C
According to the Conference of	ROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE FOLK, VA 23509	08/19/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	large amount of blood and went all over his be Resident #1 denied ar bleeding prior to and a Review of Resident's ano documentation regarday21; 7 a.m. to 7 p.  Review of Resident #1 documented in part, the Resident #1) has pote catheter direct access PICC IVMonitor for hislodgement of catheter lines. Report any abnorphysician"  Further review of Resident #1 for hislodgement of catheter lines. Report any abnorphysician"  Further review of Resident was a revealed vital signs were 2:02 p.m. The following pressure): 124 / 63 mm 96 percent room air ox vital signs were recorded and a record and a record was a record and a record a record and a record and a record a reco	a result of this incident, a had come out of his line bed, siderail and floor. By further episodes of lifter 7/23/21.  If I clinical record revealed arding the incident on m. shift.  Is care plan dated 7/25/21 e following: "(Name of Intial for infection related to to blood r/t (related to) be morrhage due to lifter, broken or disconnected rmal findings to  Ident #1's clinical record re obtained on 7/23/21 at g was recorded: BP (blood Intig. 67 beats per minute, lygen saturation. No further led for 7/23/21.  If 23/21 night shift (7 p.m. to part, the following: 13.375 (Zosyn). no ble lumen picc to RUE), patent. blood return and symptoms) of irritation d noted to bedsheets (sic), leding earlier. this nurse neets more than once,	F 5	80		
	Further review of Resid	ent #1's clinical record				

CENTERS FOR WEDICARE & WEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
	405000				С
	495309	B. WING			08/19/2021
NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN HEALTH NORFOLK			827 NO	ORVIEW AVENUE	
			NORF	FOLK, VA 23509	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580 Continued From page	a 8				
		, F:	580		
PICC line. There was bleeding from his PIC			ş		s
There was no eviden	ce of an assessment done	j			3
	ding the incident or any				
A physician note coul	d not be found in Resident	i			9 2
	garding the above incident				1
on 7/23/21.	garanig the above moldon.			a	•
On 8/18/21 at approxi	imately 2:30 n m an				
	ted with Licensed Practical	1		*	* *
Nurse (LPN) #1, the r					
	t. When asked if she could				
recall an incident whe	re Resident #1's had blood	6			r.
	C line and had leaked all				
	and floor, LPN #1 stated				
	d on one occasion. LPN #1				
	not recall the exact time she				
	t the blood was dried on the				
	nis sheets. LPN #1 stated it f blood that had leaked from				
	stated that she was not				
	ned on the previous shift 7				
	ed into his room on her first		0		
	pened later on her shift.				ti.
1 2 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	sure because she stated				*
	ave been late. LPN #1 did	i			
	ds prior to seeing the blood				
	bed, floor and rail. LPN #1				
	d cleaning up the blood				
	oor and rail. LPN #1 stated				
	PICC line and stated that it				l
	me. LPN #1 stated that the	6			
	vely bleeding at the time of				1
	#1 stated that she flushed lline and she had no issues				1
	stated that Resident #1				

OLIVILI	TOT ON MEDICANE &	WEDICAID SERVICES				OMB NO. 0938-039	91
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309	B. WING			C 08/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			STRFF	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/19/2021	_
PELICAN	HEALTH NORFOLK			827 NO	ORVIEW AVENUE		
-				NORF	FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 580	Continued From page	9	F	580			
		ges to his mental status or		,00			
	anything that would al	ert her that he was having a	Ĭ.				
	change in condition. L	PN #1 stated that the		1			
	bleeding may have be	en from the Heparin flushes	90			e II	
	that were scheduled e	very shift and now were	*	1			- 1
	ordered for PRN (as n	eeded). When asked if she					-
		assessment in the clinical	is ji				-
	record, LPN #1 stated		1			(#) (#	-
	clinical record then she		¥	9			-
		ked if she had notified the	į				- 1
		ent, LPN #1 stated that she		) - 100   0		9 3	-
	did not because the Re	esident was not having any		3.			-
	changes in his condition	on. LPN #1 stated that she	*				1
	kept checking on the re	esident to see if he had any				1	1
		what checking entailed,					- 1
	LPN #1 stated she wor	uld pop in his room and					1
	check in on him. Wher	asked if vital signs were					-
		e discovered the blood or					-
		g, LPN #1 stated she just					
	looked at the vital sign						1
	obtained earlier in the						1
	Nursing Assistant. Who						1
		lushes were in response to					1
		n 7/23/21, LPN #1 stated					1
		ay have already been an		4			1
	order prior to the incide	ent.					
	On 8/19/21 at 2:49 p.m	., Administrative Staff					
		Administrator, ASM #2,					1
	the DON (Director of N						1
		nical Services, and ASM					1
		were made aware of the					1
	above concerns.						
	Facility policy titled, "No	otification of Changes"					
		following: "The purpose of					
	this policy is to ensure						
	informs the resident, co						
1	physician; and notifies,	consistent with his or her					1

		MEDICAID SERVICES				OMB NO. 09	9 <u>38-039</u> 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		NSTRUCTION	(X3) DATE SUR' COMPLETE	
		495309	B. WING			C 08/19/2	2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				827 N	IORVIEW AVENUE		
PELICAN	HEALTH NORFOLK				FOLK, VA 23509		
040.15	CUMMARY CT	ATTACHT OF PERIODS		11010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<b>k</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) MPLETION DATE
F 580	Continued From page	: 10	! E.	580			
		epresentatives when there is		,00			
		tificationCircumstances	f			,	
		nclude:Significant change					
		cal, mental, or psychosocial		1			
		erioration of health, mental					
		s. This may includeClinical		1		1	
		continuation of current		į		6	
	treatment due to adve						
	treatment due to adve	rse consequences.	1				
	(1) Zosyn- also known	as Tazocin®					
	piperacillin/tazobactar		· ·				
		c. This information was					
		tional Institutes of Health.		1			38
		nih.gov/pmc/articles/PMC25					
	04059/.	iii.gov/priic/articles/PiviC23					
	04000/.						
	(2) Heparin Lock Flush	n- Heparin flush belongs to					
		led anticoagulants. This is	1				
		from clotting or "stopping					
		IV) line. Heparin, in the					
		lines, should not normally					
		clotting elsewhere in your					
	body. This information						
		rg/SiteCollectionDocument					
		on/InfusionTherapy/CCHH					
		SodiumChlorideFlush.pdf.					
	asionropamiana	oodidiiioildoi lusii.pui.					
	(3) PICC (peripherally	inserted central catheter)-					
		enous access device that					
		the superior vena cava				047	
		RA). They can be inserted					
	centrally (centrally inse						
		PICC). PICCs are placed					
		chial, cephalic, or medial					
	cubital vein of the arm.						
		ional Institutes of Health.					
		ih.gov/books/NBK459338/					
	>	11.904\D00v2\IADV499990\					
	<i>5</i> **						- 1

ı	OT ON WEDICARE &	WEDICAID SERVICES					OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		INSTRUCTION		(X3) DATI	E SURVEY PLETED
							l	С
		495309	B. WING				08	/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COI	DE		
PELICAN	HEALTH NORFOLK			827 N	IORVIEW AVENUE			
				NOR	FOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA	≣ .TE	(X5) COMPLETION DATE
F 580	Continued From page	11	F	580				
i	when medication was pain on 7/26/21; scheen	ed to notify the physician not administered for nerve duled insulin on 8/2/21; and a 8/6/21 for Resident #1 per						
	unspecified open wour complete traumatic am toe, acute osteomyeliti right ankle and foot, ty quadraplegia, and dee lower extremities. Resiminum Data Set (MI admission assessment reference date (ARD) owas coded as being in scoring 15 out of possi Interview for Mental St Resident #1 was coded (Medications) as received.	d on 7/26/21 with d but were not limited to not to the right foot, aputation of one right lesser s (bone infection) of the pe two diabetes mellitus, p vein thrombosis of the dent #1's most recent DS) assessment was an a with an assessment of 7/10/21. Resident #1 fact in cognitive function ble 15 on the Brief atus Exam (BIMS). If in Section N ring insulin injections.						
1	that he was out of his n for two days and also t	nt #1. Resident #1 stated nedication for nerve pain nat facility staff sometimes d sugar or give him insulin dent #1 stated he						
1	Review of Resident #1' revealed the following r 'Gabapentin (1) Tablet 1 tablet by mouth two ti	nedication for nerve pain: 600 mg (milligrams) Give						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION	OMB NO. 0938-0391
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		MOTROCTION	(X3) DATE SURVEY COMPLETED
			to deministra o			С
NAME OF F	DOWNER OF CHERTIES	495309	B. WING			08/19/2021
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			100000000000000000000000000000000000000	IORVIEW AVENUE FOLK, VA 23509	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		HOK		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 580	580 Continued From page 12		4.	1		
1 300	7 (2)		F	580		
	Review of the narcotic	ts arrived to the building on				1
	7/12/21 from pharmac	y. The count went to 0				
	(zero) on 7/26/21 at 9:	00 a.m.				
	Further review of the r	narcotic logs revealed that				:
	60 tablets were sent to	the building on 7/27/21.				*
The first dose administered from this pack was		tered from this pack was	v.			
	on 7/28/21 at 9:00 a.m	1.				
	Further Review of Res	ident #1's July MAR				
		umented that they had				
		apentin on 7/26/21 at 5 p.m.	e	8	•	ź
	and 7/27/21 at 9:00 a.i	m. and 5 p.m.		ř.		
	Review of the emerger	ncy STAT box list revealed				9
	that Gabapentin 300 m	ng (milligrams) was a	9			i i
	medication in the STAT	Γbox.		٠		
	Review of the emerger	ncy STAT box pull list from	¥			
		at the only time staff had				
	on 7/27/21 for both the	x for the Gabapentin was		7		
	shifts. 2 tablets were p					
	There was no evidence	e that staff attempted to				
		STAT box list on 7/26/21				
	at 5 p.m.					,
	There was no evidence	that Resident #1				*
		or negative outcomes on				
	7/26/21 when his Gaba dose.	pentin was missed x 1				
	4000.					
	On 8/18/21 at 12:53 p.r					
		Staff Member (OSM) #6 the				
	time facility staff tried to	#6 confirmed that the only				
		6 stated that staff did not				
	access the STAT box of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495309	B. WING				C	
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, Z ORVIEW AVENUE FOLK, VA 23509	IP CODE	08/19/2021	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIA		
F 580 Continued From page	13	F	580				
interview was attempt to administer the Gab	On 8/18/21 at 1:31 p.m. and 4:22 p.m. an interview was attempted with the nurse who failed to administer the Gabapentin on 7/26/21 at 5 p.m. She could not be reached for an interview.					į	
Review of Resident #1's August 2021 POS (Physician Order Sheet) revealed the following insulin orders:		# *** *** *** *** *** *** *** *** *** *	1				
"Admelog SoloStar So Unit/ML Inject 4 units s for DM (Diabetes Melli	olution Pen Injector (2) 100 Subcutaneously with meals Itus.						
sliding scale; if 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-550 = 10 units of r	lution Pen Injector 100 (1 Unit Dial) Inject as per not resolved in 2 hours, call subcutaneously (under the lat bedtime for diabetes,						
on 8/2/21 at 4:00 p.m. insulin and blood sugar	duled insulin was missed Resident #1's sliding scale r check was not completed to p.m. Resident #1's blood I at "301" at the next						
Further review of Resid MAR revealed that he r insulin on 8/6/21 at 11:3 nursing note was docur EATEN."	nissed his sliding scale						

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		NSTRUCTION	(X3) DATE SURY	VEY
		495309	B. WING			C 08/19/2	2021
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2	.021
DELIGAN	HEALEN MARKET			827 N	ORVIEW AVENUE		
PELICAN	HEALTH NORFOLK			100-000-00-00	FOLK, VA 23509		92
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) MPLETION DATE
F 580	Continued From page	14		500		į	
1 000	Continued From page	14	F	580			
	The nurse who failed	to administer the scheduled					
		in on 8/2/21 and 8/6/21 had				•C	
		y and could not be reached	Y	!			
	for an interview.	1 (20) (Shiphing) (3) (30)	E				
				1		i	
	On 8/18/21 at 11:38 a					i	J
		ed Practical Nurse #2, a					
		to 7 a with Resident #1					
	frequently. When aske		ű	i.			
		ne MAR, LPN #2 stated that					197
	no signatures meant the						1
		Resident #1 had ever made					- 1
	her aware that the 7 a						- 1
		V #2 stated that she did	*				- 1
		king her aware of that. LPN					ı
		e who failed to administer					
		lly passed away but she					1
	recalled that he was sl	not have had the time to do					1
		nd administer insulin before					
	the resident's meals. V	Vhen asked if she ever					
		aving a high blood sugar					
		llin being missed the shift					
	prior, LPN #2 stated th						
		sugar level of 300 was					
	high for Resident #1, L						
		hen asked if the physician					
	should be made aware	of any missed medication,					
	LPN #2 stated that the	physician should be made					
		lld be documented of all					
	missed medications.						- 1
ě							
	On 8/19/21 at 2:49 p.m						
		Administrator, ASM #2,					
	the DON (Director of N Regional Director of Cl	ursing), ASM #3, the inical Services, and ASM					

above concerns.

#5, the corporate nurse were made aware of the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN		DISTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
							С	
		495309	B. WING _	_		0	8/19/2021	
	ROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE FOLK, VA 23509	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	15	F 5	80				
	will consider factors in including but not limite Medication administer the prescriber's order. includeMedication or error occurs, the follow initiated: a. The nurse the resident's condition or health care practitio  (1) Gabapentin is commeuropathic pain (pain	e following: "The facility medication administration, and to, the following: "a. ed not in accordance with Examples missionIf a medication ving procedure will be assesses and examines and notifies the physician ner as soon as possible"  monly used to treat due to nerve damage). btained from the National						
3	rapid-acting human ins improve glycemic contractions 3 years and ol mellitus and adults with This information was ol Institutes of Health. https://dailymed.nlm.nih	Solution Pen Injector- is a ulin analog indicated to rol in adults and pediatric der with type 1 diabetes a type 2 diabetes mellitus. otained from The National n.gov/dailymed/drugInfo.cf b-4de3-866f-a280989f47f						
	1.	- 1.230 0001 GE000001711	1 1 2	i I				
,	9 p.m. medications wer	notify the physician that all e not administered to 0 per physician's order.		4				
i	Resident #3 was admitt 10/6/20 with diagnoses imited to type two diabo depressive disorder, an	that included but were not etes mellitus, major	!					

<u> </u>	TO TOTAL WEDIONINE &	I SERVICES					OMB NO. 0938-	0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495309	B. WING				C 08/19/2021	
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	CODE	1 00/13/2021	
PELICAN	HEALTH NORFOLK			827 N	FOLK, VA 23509	7002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIA	E COMPLET TTE DATE	
F 580	Continued From page	16	,   	580			ř	
	community for page 10		1	500				
	Resident #3's most recent Minimum Data Set MDS (assessment) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/5/21. Resident #3 was coded as being severely		4					
	impaired in cognitive f	unction scoring 06 out of		i			1	
	possible 15 on the Brid Status (BIMS) Exam.	ef Interview for Mental						
	During the course of a	complaint investigation, it						
	was alleged that reside	ents did not receive	-					
*	medications and treatr	nents on 12/26/20 night				8		
	shift due to the lack of							
	Review of Resident #3 Medication Administra 9/26/20; revealed that following ordered med	tion Record (MAR) for Resident #3 missed the						
	1) "Atorvastin Calcium	(Linitary 40 mag						
	(milligrams) Give 1 tab	let by mouth at bedtime for						
	high cholesterol.							
	2) Melatonin Tablet Giv	e 6 mg by mouth at						
4	bedtime for insomnia.	41111						ı
	3) Remeron 15 MG Given for depression	ve 1 tablet by mouth at						- 1
	bedtime for depression							- 1
	bedtime for depression	et 50 MG Give 1 tablet at		1				- 1
	5) Metformin HCL 500	MG Give 1 tablet by mouth						
	two times a day for dia	hetes mellitus "	1					
	two times a day for dia	betes meintus.						
	Further review of Resid	lent #3's December 2020						
		nas missed his 6:30 a.m.						
		sliding scale insulin. The		ì				
	following order was doo	cumented:						
		ulin Lispro) Inject as per						
	sliding scale:							
	If 150-199 = 2 units giv							
	200-249 = 4 units give							
	250-299 = 6 units give	6 units:						- 1

		MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B MING			С
NAME OF F	ROVIDER OR SUPPLIER	493309	B. WING			08/19/2021
	NO VIDEN ON BOTT EIEN				EET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK				NORVIEW AVENUE	
				NOF	RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 580	Continued From page	17		-00		
	300-349 = 10 units giv		F;	580		
	350-399 = 12 units 12	units:				
	400 - 450 = 14 units 1					*
		times a day for diabetes				
,	mellitus call md (Media greater or equal to 400	cal Doctor) if blood sugar is				ř
	and the second of the second					
		3's December 2020 MAR				
	revealed that his next	blood sugar check on				
	12/2//20 was at 11:30	a.m., where he read at a				9
	level of 202. 4 units of administered.	Humalog were			*	n *
	auministered.				9	in in
	There was no evidence	e in his clinical record of	1			;
	any negative outcome					
	missed medications.	related to the above				
			E .			
	There was no evidence notified regarding the a	e that the physician was above medication missed.				
	On 08/19/21 at approxi	imately 9:10 a m an				
	interview was conducte	ed with the Director of				
		ecember 2020 MAR was				
	reviewed with the DON	. The DON stated that she				
	expected staff to admin	nister all medications as				
	30 to 60 0 in 1977 to 1977	n. The DON stated that		1		1
	she was not employed					
	December and was not	sure why the medications	d)			
	were not administered.					
	representative of all me	the physician and resident				
	administered.	culcations not				i i
í	On 8/19/21 at 2:49 p.m.	Administrative Stoff				
ì	Member (ASM) #1. the	Administrator, ASM #2,				
t	he DON (Director of Nu	ursing). ASM #3 the				,
F	Regional Director of Clin	nical Services, and ASM				
#	\$5, the corporate nurse	were made aware of the				
a	above concerns.					

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495309	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER	100000	5	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		08/19/2021	
PELICAN	HEALTH NORFOLK			827 N	ORVIEW AVENUE FOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ECTION HOULD BE PROPRIA			
F 580	Continued From page	18	F	580				
	9 p.m. medications we	o notify the physician that all ere not administered to 20 per physician's order.					,	
	limited to non- traumat blood pressure, high c	s that included but were not ic brain dysfunction, high		9				
	recent Minimum Data was an annual assess Reference Date of 6/4 coded as being intact	Set (MDS) assessment ment with an Assessment /21. Resident #4 was n cognitive function scoring on the Brief Interview for			*		* !	
	During the course of a was alleged that reside	complaint investigation, it ents did not receive nents on 12/26/20 night		¥				
6 .8		d not recall if she missed 20 and 12/27/20. She could		ii				
	Review of Resident #3 Medication Administrat 9/26/20; revealed that following ordered medi	ion Record (MAR) for Resident #4 missed the						
	high cholesterol.	et by mouth at bedtime for b (percent) Instill 1 drop in or glaucoma.	9				į	

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Committee of the commit	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER	10000	D. WIITO	STREET ADDE	2500 0174 07475 747 0477	08/19/2021
ta espector agest to transfer	HEALTH NORFOLK			827 NORVIEW NORFOLK,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC EACH CORRECTIVE ACTION SHOULI OSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	Continued From page	19	F	580		
	bedtime related to Ma 4) Tylenol 8 hour Table MG Give 2 tablets by pain related to LOW B	jor Depressive Disorder. et Extended Release 650 mouth every 8 hours for ACK PAIN." The Tylenol 8 d at 10 p.m. and at 6:00				
	a.m. on 9/27/20.	•				
		dent #3's clinical record outcomes related to the t being administered.		į,		
	On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020 MAR was reviewed with the DON. The DON stated that she			* I		i .
	expected staff to admit ordered by the physicia she was not employed	nister all medications as an. The DON stated that with the facility in	i i			F
	were not administered. expected staff to notify resident representative	the physician and the				Н
	administered.					
	the DON (Director of N Regional Director of Cl	Administrator, ASM #2,		*		
	and Resident Represer #5 was not administere	ed to notify the physician ntative (RR) that Resdient id the following medication				,
	Atarvastatin Calcium 10 Trazadone 50 mg and I	r Resident #5. Diagnosis d but not limited to	e.			

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-0391
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY
	10 000000 000 0000000000000000000000000	A. BUILDIN	IG		COMPLETED
	1				С
	495309	B. WING _			08/19/2021
NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN HEALTH NORFOLK		1	827 NO	ORVIEW AVENUE	
T == OF IN TIENT NOTE OF I		1	NORF	FOLK, VA 23509	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	l ID			
PREFIX (EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	PREFIX	, 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
F 500		1			
F 580 Continued From pag	e 20	F 58	30		
Resident #5's Minima	um Data Set (MDS - an	·	i		N
assessment protocol	) a quarterly assessment	i			
with an Assessment	Reference Date of 07/09/21				8
coded Resident #5's	Brief Interview for Mental	7			3
Status (BIMS) scored	d a 15 out of a possible score	2			0
of 15 indicating no co	ognitive impairment.				
	•				
Resident #5's person	-centered care plan with a				
revision date 12/41/1	9 documented resident is an	×			
insulin dependent dia	betic. The goal: will remain	*	07		
adequate glucose lev	els and experience no				
signs/symptoms (s/s)	of hypo/hyperglycemia				
episodes. One interve	ention/approaches to	i i			
manage goal included	d: please give me				e e
medication as ordere	d. The care plan also				
included Resident #5	at risk for complications				
related to my high blo	od pressure. The goal: will	5			
remain free from my o	complications related to high				
blood pressure. One	intervention/approaches to				ů.
manage goal included	d: give the medications as				
ordered by the physic	ian/nurse practitioner.	r			
					1
During the review of F	Resident #5's Medication				ž ×
Administration Record	(MAR) for December 2020				
revealed the following	medication orders:		ì		
Insulin Glargine Soluti		et.			
subcutaneously at bed	dtime for (Type II Diabetes.)				8
Atarvastatin Calcium t	ablet 10 mg - give 1 tablet				
by mouth at bedtime for	or (hyperlipidema.)	:			
Trazadone 50 mg - giv	ve 0.5 mg (25mg) by mouth		27		
at bedtime for (insomr	nia.)				
	ve 1 tablet by mouth at				
bedtime for (insomnia.	.)				,
Nifedipine Extended R	Release (ER) - give 60 mg				
every 12 hours for (high	h blood pressure.)				
	•				
Further review of the D					
revealed evidenced the	ere were no initials by the	1			

	to reit medior tite a	I DIONID CERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
nettweller, ground the con-	PROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	nurse; indicating the nabove were not adminp.m.  On 08/19/21 at approxinterview was conduct Nursing (DON.) The I reviewed with the DOI the MAR, she stated, December 2020, but I notify the physician and doses of medications. A pre-exit conference Administrator, Director on 08/19/21 at approxing Administration team with above were not administration team.	cimately 9:10 a.m., an ed with the Director of December 2020, MAR was N. After the DON reviewed 'I was not here in expect for the nurses to d RR of any and all missed was conducted with the of Nursing and Cooperate	F	580		
	Responsible Party (RP missed dose of medica treatment) on 04/10/20 originally admitted to n Diagnosis for Resident to Heart Failure and Cl Pulmonary Disease (C Resident #11's Minimu assessment protocol) a with an Assessment Re 11/30/19 coded Reside Mental Status (BIMS) spossible score of 15 incimpairment.	ation (Albuterol nebulizer b. Resident #11 was ursing facility on 05/24/19. #11 include but not limited nronic Obstructive OPD.)  m Data Set (MDS - an a quarterly assessment eference Date (ARD) of nt #11's Brief Interview for iccored a 15 out of a dicating no cognitive		* * * * * * * * * * * * * * * * * * *		
	Resident #11's person- care plan with a revisio					

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CO	08/19/2021 DDE
PELICAN	HEALTH NORFOLK				NORVIEW AVENUE RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION BE APPROPRIATE DATE
F 580	exacerbation and resp will not experience an	with COPD and at risk for viratory distress. The goal: y signs or symptoms of	E F	580		
	show symptoms of be Some of the interventi goal include: give me	rackles, tachycardia or ing cyanotic (turning blue). on/approaches to manage my medications as ordered		i.		
ł	me for adverse effects	practitioner and monitor and/or effectiveness of my t adverse effects to my ioner.	ř ·			
	Nebulization Solution (inhaler orally twice a d review of the April 202 there were no initials b	(MAR) for April 2020, order: Albuterol Sulfate 0.63 mg/ml - one vial				
3   10 11 11	reviewed with the DON the MAR, she stated, "I December 2020, but I e	ed with the Director of ecember 2020, MAR was . After the DON reviewed				
) - ( - ) f	on 08/19/21 at approxir Administration team we	of Nursing and Cooperate				

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495309	B. WING _			C 08/19/2021		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021		
PELICAN	HEALTH NORFOLK				27 NORVIEW AVENUE NORFOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 580	Continued From page Compliant deficiency	23	F 5	580				
	. Reporting of Alleged V		F 60	9				
	SS=D 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			1. 2.	and the second s			
	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.				on guidelines for reporting Abuse and Neglect.  Admin or designee will audit incident report 3 x per week X 4 weeks to ensure an FRI is submitted for reportable incidents. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance.			
		ne results of all Iministrator or his or her						

accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495309	B. WING	³		C 08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/19/2021
55116411					827 NORVIEW AVENUE	
PELICAN	HEALTH NORFOLK				NORFOLK, VA 23509	
(X4) ID	SLIMMARY ST	TEMENT OF DEFICIENCIES		丄		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 609	Continued From page	24		609	0	
	appropriate corrective		, г	00:	9	
		is not met as evidenced				
	by:	is not met as evidenced				
		erview, staff interview,	į			
		w, clinical record review,				
		complaint investigation, it				
		acility staff failed to submit				
:		rted Incident (FRI) to the				
8	appropriate state ager	icies regarding an unusual				
		ger had walked into the	9			
	nursing facility on Sun	day, 8/22/21 with a weapon				
	in the form of a shank					
	weapon to Resident #2	2.				
	The findings included:		1		1	
	Resident #2 was admi	tted to the facility on				
	3/13/19 and readmitted				3	
9		d but were not limited to			9	
	high blood pressure, d					
	depression. Resident #	2's most recent Minimum	0 U 0			
	Data Set (MDS) asses					
		sessment Reference Date				
		ent #2 was coded as being				
		cognitive function scoring				
		n the Brief Interview for				
		IMS). Resident #2 was ny behaviors during the 7				
	day look back period.	iy benaviors during the 7	į			
	day look back period.					3
	On 8/17/21 at 10:55 a.i	m., an interview was	**			,
		nt #1, another sampled			9	
	resident. Resident #1 s	tated that he had made an				
		complaint and added new				
		Sunday (8/22/21). Resident				1
	#1 stated that last Sund					
	approximately 6 p.m., a		1			
		the building with what				
	appeared to be a shanl	in his hand. Resident #1				

		T SERVICES				OMB NO. 09:	<u>38-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURV COMPLETE	
		495309	B. WING			C 08/19/20	024
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/19/20	021
PELICAN	HEALTH NORFOLK			827 N	ORVIEW AVENUE FOLK, VA 23509		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) IPLETION DATE
F 609	Continued From page	25	F	609			
		the hallway when he saw		000			
	the gentleman come of	onto the nursing unit, walk					
	down the hall and han	nd the shank to a resident	Į.	į			
	(Resident #2) who wa	s sitting in her wheelchair					
	on the hallway. Reside	ent #1 stated that a nursing				ì	
	aide who was also a v	vitness to this incident,		:			
		d and removed the shank					
	Review of the Facility	Reported Incidents (FRIS)		1			
	revealed no evidence	that this incident has		ž x	W		989
	occurred.	and this moldent has					
	3			- E	ar a		
	On 8/18/21 at 11:15 a.	m., an interview was					
	conducted with Certifie	ed Nursing Assistant (CNA)					
	#3, the CNA who was	witness to the above					
		#1. When asked what had					
	occurred on Sunday 8	/22/21, CNA #3 stated that		1			
	a gentleman was seen	on the nursing unit with	16				1
	what appeared to be a	shank in his hand. CNA #3					
	stated that she witness						
		ing in her wheelchair on					
	the hallway. When ask	ed if the resident and man					1
		#3 stated that she was not					
	sure. CNA #3 stated th					1	- 1
		m the resident's (Resident					- 1
		tated that the DON was					
		ding and a witness. CNA					- 1
	#3 stated that the DON						
	immediately and the m						- 1
	sho wasn't cure what d	rrived. CNA #3 stated that		*			
		oor the man entered from, was always locked. CNA					
		ite a witness statement.					
	CNA #3 could not recal	If the exact time the man					
	had entered the buildin						
	Sinor Sa tilo Dallalli	ઝ•					
	On 8/18/21 at 1:17 p.m	an interview was		V.			
		strative Staff Member #2					- 1

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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE SURVEY COMPLETED
			, 50.15			С
		495309	B. WING_			08/19/2021
	ROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509	33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 609	Continued From page	26	F 6	09		,
	the Director of Nursing FRI or incident report an incident on Sunday entering the building vistated, "No, because immediately." When a	g (DON). When asked if a was completed regarding y, 8/22/21 regarding a man vith a weapon, ASM #2				
	conducted with ASM a recall the events on 8, she was in the building cart because a nurse stated that at approxing sitting at the nurses st unidentified gentlemand walked down the gree	m., further interview was #2. When asked if she could #22/21, ASM #2 stated that g working on a medication had called out. ASM #2 nately 6 p.m., she was ation when she saw an enter the nursing unit and in hall. ASM #2 stated that follow the man as he was	Second Sec			
	walking really fast. AS asking "Can I help you continued to walk to the then turned around an of the pink hall. ASM # saying that he was loo was personal. ASM #2 Resident #2) was sittir end of the pink hall who to the man. ASM #2 st	M #2 stated that she kept with something?" and he the therapy department and d walked quickly to the end stated that the man kept king for someone, that it				:
	immediately took the s stated that she was ca man then stated, "Go a am walking toward tide stated the man then le stated that the police h description to the polic police had told her to j	aide was right there and crewdriver away. ASM #2 Illing the police and that the ahead, I am leaving and I ewater drive." ASM #2 ft the building. ASM #2 and arrived and she gave a e. ASM #2 stated that the lust throw the object away. ect was more like a shank		4		: #

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С		
		495309	B. WING			08/19/2021		
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00,10,2021		
PELICAN	HEALTH NORFOLK			827 N	NORVIEW AVENUE			
				NOR	RFOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
E 600	Cantinual F	07						
F 609	Continued From page		F	609				
	and not a screwdriver	, ASM #2 stated, "It was						
	very pointy and sharp	." When asked the	i					
	Resident #2 was place	t #2, ASM #2 stated that santly confused and had	3					
		d if the resident could have						
		self with this object, ASM				"		
	#2 stated that it was ta	aken out of her hands	1					
	immediately; that it wa	sn't even in her hands for a						
	second. ASM #2 state	d that the police stated that	1					
	if man returns, they wi	ll arrest him for						
9	trespassing. ASM #2 s	stated that all the doors				ä		
		lding at all times so she		×				
	was not sure how this					*		
		e believed someone may						
	facility. When asked w	were walking out of the						
	stonned on the weeke	nd, ASM #2 stated that she						
	would have to check w	rith activities but that						
	window visits can still			è				
		ed if a FRI for this unusual						
		e been submitted to the				1		
	appropriate state agen	cies, ASM #2 stated that it						
	wasn't that unusual. W	hen stated that it wasn't		3				
	unusual for a stranger	to enter the building with a						
	weapon, ASM #2 clarif					1		
	nomeless people are a	lways in the parking lot.						
	ASIVI #2 stated that this	s man was not aggressive				:		
		residents. ASM #2 also did not involve a resident.	ø					
	When asked if Resider							
	shank, ASM #2 stated,							
		hurt herself if staff were				8"		
		ated, "Possibly if no one		3.				
	was there."	, , , , , , , , , , , , , , , , , , , ,		185				
	On 8/19/21 at 2:49 p.m	Administrative Stoff						
	Member (ASM) #1 the	Administrator, ASM #2,						
	the DON (Director of N	ursing). ASM #3 the						
	Regional Director of Cli	nical Services, and ASM						

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ C 495309 B. WING 08/19/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **827 NORVIEW AVENUE** PELICAN HEALTH NORFOLK NORFOLK, VA 23509 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 Continued From page 28 F 609 #5, the corporate nurse were made aware of the above concerns. Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g.. law enforcement when applicable) within specified time frames...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury... Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: ...Defining how care and provisions will be changed and or improved to protect residents receiving services..." (1) Shank- a makeshift, knife like weapon. This information was obtained from https://lawenforcementmuseum.org/2010/01/20/c ontraband-weaponsshivs-and-shanks-a/. COMPLAINT DEFICIENCY F 610 Investigate/Prevent/Correct Alleged Violation F 610 SS=D CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse. neglect, exploitation, or mistreatment while the

investigation is in progress.

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STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X	3) DATE SURVEY COMPLETED
							- 1	С
		495309	B. W	NG_				08/19/2021
NAME OF PROVIDER OR SUPPLIER				STREE	T ADDRESS, CITY, STATE, ZIP CODE			
PELICAN HEA	LTH NORFOLK					DRVIEW AVENUE FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID REFIX TAG	5	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE

#### F 610 Continued From page 29

§483.12(c)(4) Report the results of all investigations to the administrator or his or her 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 resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to initiate a facility investigation regarding an unusual incident where a stranger had walked into the nursing facility on Sunday, 8/22/21 with a weapon in the form of a shank (1) and handed this weapon to Resident #2; AND failed to put interventions in place to ensure safety to all residents in response to this incident.

#### The findings included:

Resident #2 was admitted to the facility on 3/13/19 and readmitted on 2/15/20 with diagnoses that included but were not limited to high blood pressure, dementia, anxiety, and depression. Resident #2's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/8/21. Resident #2 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #2 was coded as not having any behaviors during the 7 day look back period.

On 8/17/21 at 10:55 a.m., an interview was

#### F 610

- Investigation regarding the unusual event was completed on 8-23-2021 and an action plan was initiated.
- Although no resident was harmed all residents are at risk when the facility fails to complete a thorough investigation following an unusual occurrence
- Education was provided to licensed staff on the investigation of resident incidents and escalation of adverse events to the facility leadership. Staff received education on the process of responding to door alarms and ensuring building is secure.
- 4. Incident reports will be audited 3 x per week for 4 weeks to ensure thorough investigation are completed for any reported or risk incidents. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
- 5. DOC 10/3/21

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MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
495309	B. WING _		C 09/40/2024
•		STREET ADDRESS, CITY, STATE, 827 NORVIEW AVENUE NORFOLK, VA 23509	ZIP CODE
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETION OF TO THE APPROPRIATE DATE CIENCY)
ent #1, another sampled stated that he had made an complaint and added new Sunday (8/22/21). Resident had an one stranger from off the er the building with what hak in his hand. Resident #1 the hallway when he saw onto the nursing unit, walk had the shank to a resident s sitting in her wheelchair ent #1 stated that a nursing witness to this incident,	F 61		
ntation that this incident vas no further evidence in cating that Resident #2 was self or others.  Reported Incidents (FRIS) that this incident has  m., an interview was sertified Nursing Assistant to was witness to the above \$1. When asked what had \$122/21, CNA #3 stated that on the nursing unit with shank in his hand. CNA #3 sed the man hand the ing in her wheelchair on			
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  2 30  ent #1, another sampled stated that he had made an complaint and added new Sunday (8/22/21). Resident and stranger from off the er the building with what his in his hand. Resident #1 the hallway when he saw onto the nursing unit, walk did the shank to a resident s sitting in her wheelchair ent #1 stated that a nursing witness to this incident, d and removed the shank  2's clinical record failed to intation that this incident vas no further evidence in cating that Resident #2 was self or others.  Reported Incidents (FRIS) that this incident has  m., an interview was ertified Nursing Assistant to was witness to the above #1. When asked what had ('22/21, CNA #3 stated that on the nursing unit with shank in his hand. CNA #3 sed the man hand the ing in her wheelchair on ed if the resident and man	(X2) MULTIPLE CONSTRUCTION A. BUILDING  495309  B. WING  STREET ADDRESS, CITY, STATE, 827 NORVIEW AVENUE NORFOLK, VA 23509  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL S.C. IDENTIFYING INFORMATION)  PREFIX TAG  TAG  F 610  F 6

sure. CNA #3 stated that she immediately

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

OLIVILI	STON WEDICARE &	WEDICAID SERVICES				OMB NO. 0938-039	11	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ISTRUCTION	(X3) DATE SURVEY COMPLETED	the state of the s	
		495309	B. WING			C 08/19/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00.10.2021	_	
DEL 10 4 11					DRVIEW AVENUE			
PELICAN	HEALTH NORFOLK				OLK, VA 23509			
	CIMALENATION			NOKI				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 610	Continued From page	31	E 1	610				
		om the resident's (Resident	· I''	310				
	#2's) bands CNA #2	on the resident's (Resident					- 1	
	also procent in the bui	stated that the DON was Iding and a witness. CNA						
	#3 stated that the DOI	Iding and a witness. CNA	1.0				1	
		nan had left the building				TK.	١	
							- 1	
		arrived. CNA #3 stated that door the man entered from,					- 1	
		was always locked. CNA					- 1	
		rite a witness statement.					-	
		all the exact time the man					-	
	had entered the building							
	riad entered the building	ig.						
	On 8/18/21 at 1:17 p.n	an interview wee					1	
		strative Staff Member #2,					1	
		(DON). When asked if a					1	
		was completed regarding	1				1	
		, 8/22/21 regarding a man					1	
	entering the building w							
	stated, "No, because I					K	1	
		sked if she figured out what	1				1	
		from, ASM #2 stated, "No."					1	
	door the man entered	non, Adm #2 stated, No.						
	On 8/18/21 at 2:24 n m	n., further interview was				790	1	
	conducted with ASM #	2. When asked if she could	)4 (2			4	1	
		22/21, ASM #2 stated that	,				1	
		working on a medication					1	
	cart because a nurse h						١	
	stated that at approxim						1	
	sitting at the nurses sta	ation when she saw an	1				1	
	unidentified gentleman	enter the nursing unit and	*			*	1	
	walked down the green	hall. ASM #2 stated that					1	
	she quickly got up to fo	llow the man as he was	5				1	
	walking really fact ACM	#2 stated that she kept						
	asking "Can I help you	with something?" and he	*				1	
		e therapy department and						
		therapy department and walked quickly to the end						
		2 stated that the man kept						
	saying that he was look was personal. ASM #2	king for someone, that it stated that (Name of						

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES			4	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		495309	B. WING			08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
PELICAN	HEALTH NORFOLK			827 1	NORVIEW AVENUE	
LLIOAN	HEALITI NORFOLK			NOF	RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
= -10				7		
F 610	· · · · · · · · · · · · · · · · · ·		F	610		
	Resident #2) was sitti	ng in her wheelchair at the		2		
		nen she introduced herself	į.			
		tated that was when the				
		ent a screwdriver. ASM #2		1		
		g aide was right there and				
	immediately took the s	screwdriver away. ASM #2				
	stated that she was ca	alling the police and that the				
		ahead, I am leaving and I				
	am walking toward tide					
	stated the man then le	eft the building. ASM #2				
		nad arrived and she gave a				u
		ce. ASM #2 stated that the		18		
	police told her to just t					
		ect was more like a shank				
		ASM #2 stated, "It was		1		
	very pointy and sharp.					
		t #2, ASM #2 stated that				
		santly confused and had				
		d if the resident could have				
	#2 stated that it was ta	self with this object, ASM				
			9			
		sn't even in her hands for a d that the police stated that				
	if man returns, they wil	I arrest him for				er.
	trespassing. ASM #2 s					
		ding at all times so she				
		man got in the building.	×			
		e believed someone may				
		were walking out of the				
	facility. When asked w		i			
		nd, ASM #2 stated that she				
	would have to check w	ith activities but that				
	window visits can still of					
		ed if a FRI for this unusual				
		e been submitted to the				
		cies, ASM #2 stated that it				
		hen stated that it wasn't		1.		
		to enter the building with a				
	weapon, ASM #2 clarifi	ied and stated that				1

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CENTER	<b>REPORT MEDICARE &amp;</b>	MEDICAID SERVICES				OMB NO. 09	38-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURV	VEY
						С	
		495309	B. WING			08/19/2	021
NAME OF P	PROVIDER OR SUPPLIER			STRE	REET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK		1	827 1	NORVIEW AVENUE		
	TEACHTRON 51.			NOF	RFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETION DATE
F 610	Continued From page	a 33	F	610			
		always in the parking lot.	1)	* -			
	ASM #2 stated that th	nis man was not aggressive		4			
,	towards the staff or th	ne residents. ASM #2 also	1				
		nt did not involve a resident.					
		ent #2 was handed the					
,	shank, ASM #2 stated						
1	Resident #2 could have	ve hurt herself if staff were	9				
		stated, "Possibly if no one					
		stated that the doors were				# #	
	always locked and cou	ould not be entered from the		3.			
. 6	outside unless let in. \	When asked if there was			a .	-	
		this man come into the					
	building, ASM #2 state		6	1	2	2	
li p		ne in the building. When	e e				
		witness statements on this					
		investigation to determine					
		the building; ASM #2 stated				K E	
		n asked if anything was put	+				
		his from occurring again,					
	ASM #2 stated that the						
		urs at the front desk but she					
		s of the hours. ASM #2 also					
		valk through of the building					
		nsure all doors remained					
		d that evening shift nurses					
		check all doors. ASM #2	ì			Ĭ	
		not shut all the way, it will					
	alarm except the front						
		no alarms were going off so				*	
		e front lobby doors. ASM #2					
		way to disable the lock to					
		hat is why she believes the					
	man came in while son						
		ovided any in services or					
		the building or ensuring					
		re not entering the building					
		ASM #2 stated that sho					

did not do any in services or education.

TICES FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO TOIL WEDICAILE &	WEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING	<u> </u>		C
NAME OF P	PROVIDER OR SUPPLIER				ET ADDRESS CITY STATE ZID CODE	08/19/2021
***************************************					ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK				IORVIEW AVENUE	
	0.11.11.15.1.5			NOKI	FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(7
F 610	Continued From page	∋ 34	F	610		
		m., a tour and observation	-			
		loors were conducted by two				
		ncluding the lobby doors				
		pened from the outside				
		est to the facility dumpsters.				
j		red at 4:00 p.m. with a code				
ĵ	lock. The door was ab	ole to be opened, however				
	an alarm had sounded	d. It took staff one minute		T.		
	(4:01 p.m.) to respond	d to this alarm. Other Staff				
	Member (OSM) #5, th	ne Dietary Manager stated				
	that the door was not	supposed to open unless a	Y.			
is .	code was entered into	the keypad. OSM #4, the				
		ce then arrived and stated				
		ot have opened from the	ij.			
		ed that he wondered if the		1		
		perly when staff went out of				
		he exit door was used for,				
		ousekeeping used that door				
		impsters. OSM #4 then shut				
		nd it did not reopen from the				
		or third attempt. OSM #5				
		en staff used another door				
		en to access the facility				
	dumpsters. This door t					
		erved. This door was not				
		ave a code lock. OSM #5				
		vays staff in the kitchen and				
		locked using a bolt lock	Į.			
		M #5 stated kitchen staff	Ĭ.			
	there is no way to look	that door for the night, as				
	there is no way to lock	it from the outside.				
	On 8/18/21 at 4:44 p.m	n an interview was				
	conducted with the Co					
		22/21 during the evening				
		that he stays in the kitchen				
		.m. on the weekends. OSM				
		g a man enter through the				
		usekeeping exit door. OSM				

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OLIVILI	TO TON MEDICANE &	WEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			С
NAME OF P	ROVIDER OR SUPPLIER					08/19/2021
10 mil 01 1	NOVIDER OR COLL ELER				ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK				ORVIEW AVENUE	
				NORI	FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 610	Continued From page	35	_	040		
1 010			F	610		
		to make sure the kitchen				2
		to leaving. OSM #3 then				
		eeping exit door will open				
		the door is not latched				
	properly when staff ex	it the door. OSM #3 stated				·
		will alarm if the door is				
	opened or left opened	•	ï			
	On 9/19/21 at annewi	motoly E man and internal				
	was conducted with A	mately 5 p.m., an interview SM #1, the Administrator.				i i
,		s done in response to the	ş			
		day on 8/22/21, ASM #1				
		ed the hours for the front	t e			
		p.m. on the weekends,				
		ember would be at the front	41			-C
		es. When asked how this				
	would help when the n	nan had entered the				
		ely 6 p.m., ASM #1 stated				
	that she is also having	activities stay until 7 p.m.				
	to watch the front desk		i			
	comes through the from					
	<b>O</b> 17 10 65					
	On 8/19/21 at 11:27 a.	m., an interview was				
		2, the Activities Director.				
		e does work the weekends				
	that was recently told h	ner hours will be extended		!		
	during the weekends. \	When asked why her hours				
	are being extended, O	SM #2 stated to provide	2			
	more activities to resid	ents. When asked when				
	she was told her hours	would be extended, OSM				
		metime last week. When				
	asked if she was told the	nis past Sunday, OSM #2				Î
	stated that she was tol	d before Sunday.				
	On 8/19/21 at 2:49 p.m	Administrative Staff				
		Administrator, ASM #2,				
	the DON (Director of N					i
		inical Services, and ASM				
		were made aware of the				
	, co.porato nuist	Induo amaic of the				

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTI BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309		WING			С	
NAME OF F	ROVIDER OR SUPPLIER	493309		WING_			08/19/2021	
	HEALTH NORFOLK				827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	İ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 610	Continued From page above concerns.	36	a Y	F 61	10			
	"Reporting of all alle Administrator, state ag services and to all other law enforcement when specified time frames the events that cause involve abuse and do injuryTaking all nece the investigation, which limited to, the following	ats in part, the following: ged violations to the gency, adult protective er required agencies (e.g., applicable) withinNot later than 24 hours if the allegation do not not result in serious bodily ssary actions as a result of may include, but are not ged and or improved to						
	information was obtain	museum.org/2010/01/20/c vs-and-shanks-a/.	8		3	,		
F 658		t Professional Standards		F 658	3			
	as outlined by the comp must- (i) Meet professional sta This REQUIREMENT i by: Based on staff interview and clinical record revise facility staff failed to foll of practice and docume	or arranged by the facility, prehensive care plan,						

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495309	B. WING_		08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2021
PELICAN	HEALTH NORFOLK			827 NORVIEW AVENUE	
				NORFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 658	Continued From page	: 37	!		
		rmacy and not accessed	F 658	3	
	nom the emergency s	STAT DOX ON 7/26/21.	1	Modication Cabanastic	
)	The findings include:		1	Medication Gabapentin was re- Resident #1 on 8/28/21.	ceived at facility for
	Resident #1 was admi	ittad to the facility an	2	. All residents have the potential	to be affected when
0	7/10/21 and readmitte	d on 7/26/21 with	0	professional standards of pract	
		ed but were not limited to	3		
	unspecified open wou	nd to the right foot	9		
	complete traumatic an	nputation of one right lesser		on medication administration a	C. A. Market Company Manager of the
	toe, acute osteomyelit	is (bone infection) of the		and notification of MD if medic	ation is unable to be
	right ankle and foot, tv	pe two diabetes mellitus,		given.	
	quadraplegia, and dee	p vein thrombosis of the	4	. DON will conduct audits of 5 me	edications on 10
	lower extremities. Res			residents weekly x 4 weeks com	The Contract Contract of Contract of States of Contract of Contrac
		DS) assessment was an			
	admission assessmen	t with an assessment		medication availability. Results	
		of 7/10/21. Resident #1		reported monthly to the QAPI C	
	was coded as being in	tact in cognitive function		committee is responsible for the	e on-going
* :	scoring 15 out of possi	ble 15 on the Brief		monitoring for compliance	
	Interview for Mental St	atus Exam (BIMS).	5	DOC 10/3/21	
	On 8/17/21 at 10:55 a.	m., an interview was			
	conducted with Reside	nt #1. Resident #1 stated			
		nedication for nerve pain			
	for two days.	<b>F</b>	*		
į	Review of Resident #1	s July 2021 orders			
1	revealed the following i	medication for nerve pain:	1		
* 1	'Gabapentin Tablet 600	) mg (milligrams) Give 1			1
t	ablet by mouth two tim	es a day for pain."			
) i	Review of the narcotic	logs for Gabapentin			
r	evealed that 30 tablets	arrived to the building on			
	7/12/21 from pharmacy				
(	zero) on 7/26/21 at 9:0	0 a.m.			
F 6	Further review of the na 30 tablets were sent to	arcotic logs revealed that the building on 7/27/21.			

The first dose administered from this pack was

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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		MEDICAID SERVICES				OME	3 NO. 0938-0391
STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		INSTRUCTION		DATE SURVEY COMPLETED
		495309	B. WING				C 08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		00/13/2021
DEL 10 4 11					IORVIEW AVENUE		
PELICAN	HEALTH NORFOLK				FOLK, VA 23509		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ın.				
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	Continued From page	38		658			
	on 7/28/21 at 9:00 a.n		, -	030			
	011 7720721 at 9.00 a.11						
	Further Review of Res	sident #1's July MAR	<b>6</b> .				Ü
		cumented that they had					
		apentin on 7/26/21 at 5 p.m.	1				
	and 7/27/21 at 9:00 a.		9				a
		ncy STAT box list revealed					
	that Gabapentin 300 n	ng (milligrams) was a					
	medication in the STA	T box.	i i				
	Pavious of the amores	TOU CTAT have multiple for an					
		ncy STAT box pull list from at the only time staff tried to					
		for the Gabapentin was on					
	7/27/21 for both the me	orning and evening shifts. 2					
	tablets were pulled to	equal 600 mg. There was					
		attempted to access the					1
	emergency STAT box	list on 7/26/21 at 5 p.m.					
	There was no evidence						
	experienced any pain	or negative outcomes on					
		apentin was missed x 1	9				
	dose.						
	On 8/18/21 at 1:31 p.m	n. and 4:22 p.m. an					l
		ed with the nurse who failed	s.				i
	to administer the Gaba	pentin on 7/26/21 at 5 p.m.					
	She could not be reach						
				3			
	On 8/18/21 at 11:38 a.i						
		ed Practical Nurse #2, a					
		to 7 a with Resident #1					
	rrequently. When asked	d the process for obtaining					
		rgency STAT box, LPN #2					ā
		to call pharmacy to obtain					
	a code in order to pull r						
	okay to sign off that a r	When asked if it was ever					
		ent when it was not given					

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

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	FOF DEFICIENCIES DEF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING	B. WING		C
Vennamental Institut on Victoria	PROVIDER OR SUPPLIER			827 N	IET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509	08/19/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 658	it wasn't given."  On 8/18/21 at 12:53 p conducted with Other lead pharmacist. OSM time facility staff tried to was on 7/27/21. OSM access the STAT box of the DON (Director of Nagional Director of City, the corporate nurse above concerns.  Facility policy titled, "Maccess the STAT box of the DON (Director of City, the corporate nurse above concerns.  Facility policy titled, "Maccess the STAT box of the DON (Director of City, the corporate nurse above concerns.  Facility policy titled, "Maccess the STAT box of the DON (Director of City, the Corporate nurse above concerns.  Facility policy titled, "Maccess the STAT box of the DON (Director of City, the Corporate nurse above concerns.  Facility policy titled, "Maccess the STAT box of the DON (Director of Nagional Director of City, the Cit	e not supposed to sign off if  m., an interview was Staff Member (OSM) #6 the #6 confirmed that the only o access the STAT box #6 stated that staff did not on 7/26/21.  n., Administrative Staff e Administrator, ASM #2, lursing), ASM #3, the inical Services, and ASM e were made aware of the dedication Administration" following: "Sign MAR after	F	658		
F 677 SS=E	out activities of daily liv	NCY Dependent Residents  It who is unable to carry ing receives the necessary od nutrition, grooming, and ene;	F 6	77		

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO 0020 0204

					OMB NO. 0936-039 I
STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING		C 08/19/2021
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN HEALTH NORFOLK				827 NORVIEW AVENUE NORFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		E COMPLETION
10			Y		The state of the s

#### F 677 Continued From page 40

Based on observation, resident and staff interviews and clinical record review the facility staff failed to ensure 3 of 11 residents (Resident #6, Resident 11 and Resident #8) in the survey sample who were unable to carry out activities of daily living (ADL) receives the necessary care services.

#### The findings included:

1. The facility staff failed to ensure Resident #6 received showers twice a week. Resident #6 was originally admitted to the nursing facility on 05/11/21. Diagnosis for Resident #6 included but not limited to Congestive Heart Failure (CHF.)

Resident #6's Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date of 05/18/21 coded Resident #6's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #6 total dependence of one with bathing, extensive assistance of one with bed mobility and dressing, limited assistance of one with transfer, eating, toilet use and personal hygiene for Activities of Daily Living (ADL) care.

The care plan dated 05/27/21 identified Resident #6 with ADL self-care performance deficit. The goal set for the resident by the staff was that the resident will maintain and improve current level of function. One of the interventions/approaches the staff would use to accomplish this goal for a dependent resident is that staff is to provide bath/shower (specify frequency) and as necessary.

#### F 677

- 1. Shower room was cleared and cleaned 8-20-2021. Shower schedule in place 8-20-2021 for indicated residents. Resident #6 shower completed on 8-24-2021 and 9-1-2021 and Resident #8 on 9-7-2021. Resident #11 was discharged on 1-29-2021. Resident #8 nails were trimmed on 8-18-2021. Residents with shower preferences were added to current shower schedule.
- 2. All residents who are dependent on staff for ADL's are at risk when care is not provided/offered.
- 3. 100% of Residents will be surveyed regarding shower vs bathing preferences and care plans will be updated to reflect resident's bathing/shower preference. Staff education will be provided to certified staff to include; provision of nail care, following resident shower schedule and how to address resident refusals.
- 4. Audits will be conducted to ensure shower and nail care is being provided according to schedule 3 X a week for 4 weeks. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance.
- 5. DOC 10/3/21

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495309	B. WING			C 08/19/2021	
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH NORFOLK		•	827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509	1 00/13/2021	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO	NC
were not given for the er and has not been given as of 08/17/21.  On 08/18/21, the facility of resident #6's shower s	mately 11:05 a.m., an d with Resident #6 who one shower since I've sility." The resident we never refused my on't ask."  It documentation survey ed the following: Showers interementh of July 2021 for the month of August provided documentation scheduled: Resident #6 e showers every Tuesday  It will be a shower on 08/13/21. The CNA was assigned er shower on 08/13/21. The CN	F	677			

PRINTED: 08/31/2021 FORM APPROVED

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OM	IB NO. 093	8-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3)	) DATE SURVE COMPLETED	
		495309	B. WING				C	
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	08/19/20	21
					NORVIEW AVENUE			
PELICAN	HEALTH NORFOLK							
	CUMMANU OT			NOR	FOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COM	(X5) PLETION PATE
F 677	Continued From page	42		677			N	
	care to include showe			011				
	care to include showe	is for Resident #6.	İ					
	An interview was cond	ducted with the Director of	7.40					
		19/21 at approximately 9:13						
		he expect for the CNA's to		į.				
		hower schedule and notify						
		e resident refuses. The						
		ent the refusal in Point Click						
	Care (PCC) and the n	urse is to document the						
	refusal in the resident	s clinical record.						
	O The feetile	5-16	9		×			
		led to ensure Resident #11						
		e a week. Resident #11 d to the nursing facility on						
	05/24/19 Diagnosis f	or Resident #11 included						
	but not limited to musc	cle weakness.						
	Docident #11's Minima	um Data Oat (NADO						
		ım Data Set (MDS - an a quarterly assessment						- 1
		eference Date (ARD) of						
	11/30/19 coded Reside	ent #11's Brief Interview for						
	Mental Status (BIMS)							ĺ
	possible score of 15 in							1
		n, the MDS coded Resident						1
	#11 limited assistance	of one with bed mobility						i
	2 D 720 D	sion with dressing, toilet	i i					
	use, personal hygiene	and bathing						- 1
	for Activities of Daily Li	ving (ADL) care.						
	The care plan dated 04	5/25/19 with a revision date	1					
		requiring assistance with						
	ADL's at times. The go	al set for the resident by						
	the staff was that the re	esident abilities will be						
		an and free of body odor,						
	will be groomed and w							
		interventions/approaches						
		accomplish this goal is that	ii.					

staff to assist bathing when needed.

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/13/2021
DELICAN	LICALTUNOPEOUX			827 N	ORVIEW AVENUE	
PELICAN	HEALTH NORFOLK				FOLK, VA 23509	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID			y.
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 677	Continued From page	43	F	677		
		11's documentation survey				
	report for bathing reve	aled the following: Showers				
	2020 and only given to	entire month of December				c
	November 2020; on 1					
	110101111011 2020, 011 1	1700 and 11722720.				
	An interview was cond	lucted with the Director of				
		19/21 at approximately 9:13				
	a.m. The DON said sl	ne expect for the CNA's to				9.
		nower schedule and notify				
*		resident refuses. The				
	CNA is also to docume	ent the refusal in Point Click				
	refusal in the resident's	urse is to document the				d.
	relusar in the resident:	s clinical record.				ü
	3. The facility staff fail	ed to ensure that fingernail				
	care was provided to F	Resident #8. Resident #8				
	was originally admitted	to the facility on 10/23/17.				
	Diagnosis for Resident	#8 included but not limited				
	to Heart Failure and Ty	pe II Diabetes.				
	The current Minimum I	Data Set (MDS) a quarterly				
	assessment with an Ac	sessment Reference Date				
		ed Resident #8 with a 15				
	out of a possible score	of 15 on the Brief				
		atus (BIMS) indicating no				
	cognitive impairment.	In addition, the MDS coded				
	Resident #8 requiring t	otal dependence of one				
	with bathing, extensive	assistance of two with				в.
К.	transfer and toilet use,	limited assistance of two				
į	with bed mobility and d	ressing, limited assistance				
,	of one with personal hy	giene.				
	The care plan with a re	vision date of 10/23/20				
i	identified Resident #8 v	vith ADL self-care				
	performance deficit rela					
		goal set for the resident by				
	the staff was that the re					

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

STATEMENT	OF DEFICIENCIES	(VA) PROMERRIAN INC.				OMB NO. 0938-0391
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		405000				С
		495309	B. WING			08/19/2021
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			1	ORVIEW AVENUE FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
			gi.	7.0		
F 677	Continued From page	44	F	677		
	current level of function	on with ADL's. One of the				
		hes the staff would use to				
	accomplish this goal is					
	during bathing/shower	ring to check nail length and	i			
	trim and clean on bath	day as necessary; report				9
		rse. Resident #8's showers				
		very Monday and Thursday				
	(7a-7p) shift.					
						*
	During the initial tour of			20		
	approximately 10:50 a	.m. Resident #8 was				
	observed lying in bed	with her hands on the			*	
	Decident #9's finances	The surveyor observed				į
		ils were very long with a		1		
	day at approximately 1	er the nails. On the same				
		nchanged. Resident #8				
		long and nasty, they need				
	to be cut/soaked and fi	iled. Resident #8 stated,	1			
		fingernails?" On the same				
	day at approximately 1	:50 p.m., License Practical				
	Nurse (LPN) #4 assess	sed Resident #8's				
	fingernails with the sur	veyor present. The LPN	į			
	stated, "Yes, Resident	#8's fingernails need to be				
	cleaned/cut and trimme	ed, I'll take care of it today."		ä		
	2.220					
	On 08/18/21 at approxi	mately 9:10 a.m., Resident	i			
	#8's fingernails had be					-
	Resident #8 stated, "Th	nank you for getting my				
	fingernails taken care of					
	trying for weeks to have fingernails."	e tne staff cut my	195			
						1
	A pre-exit conference w	vas conducted with the				ļ
		of Nursing and Cooperate	ì			
	on 08/19/21 at approxir	nately 3:30 p.m. The				İ
		ere informed of the above				
		rmation was provided prior				
	to exit	a very act act acts that the property is the first				

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

PRINTED: 08/31/2021 **FORM APPROVED** 

	T OF THE CENTION				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495309	B. WING		C 08/19/2021	
NAME OF PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
PELICAN HEALTH NORFOLK		827 NORVIEW AVENUE NORFOLK, VA 23509			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 677 Continued From page	45	F	677		-

Complaint deficiency F 684 Quality of Care

SS=E CFR(s): 483.25

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced

Based on resident interview, staff interview, clinical record review, facility document review. and in the course of a complaint investigation it was determined that facility staff failed to adequately assess and monitor a diabetic foot ulcer and obtain a new treatment in a timely manner for one of 11 sample residents, Resident #1; failed to follow wound care orders for one of 11 residents, Resident #1; failed to adequately assess and monitor a resident's change in condition related to a PICC line for one of 11 residents, Resident #1; AND failed to follow physician orders for five of 11 sampled residents; Resident #1, #3, #4, #5 and #11.

#### The findings include:

1. Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot. complete traumatic amputation of one right lesser

#### F 684

1. Resident #1 had no further episode with PICC line after 7/23/21. PICC line was flushed at time of incident, patient was monitored for signs of adverse effects, no negative signs and symptoms was indicated. PICC line was discharged on 9/1/21. Resident #3 received Metformin HCL on 12/26/20, remaining medications were all administered on 12/28/20. Resident #3 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #4, all medications were administered on 12/27/20. Resident #4 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #5 received all medication on 12/27/20, except for Trazodone which was administered on 12/28/20. Resident #5 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #11 received medication on 4/11/20. Resident #11 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #1 had skin assessment completed on 7-26-2021. Resident #1 wound care orders were completed on 7/25/21. Resident #1 received nerve pain and insulin per physician's orders on 7/30/21.

		ND HUMAN SERVICES				FORM APPROVED
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WIN	G		C 08/19/2021
NAME OF P	PROVIDER OR SUPPLIER			$\top$	STREET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN				827 NORVIEW AVENUE		
1 22.07.11					NORFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684	minere i rem page		-	F 684	4	
	right ankle and foot, ty quadraplegia, and dee lower extremities. Res	tis (bone infection) of the  ppe two diabetes mellitus,  ep vein thrombosis of the  sident #1's most recent  IDS) assessment was an		2.	<ul> <li>All residents are at risk when changes are not assessed and monitored time MD orders are not followed</li> </ul>	

admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded as requiring extensive assistance from one staff with bed mobility, and toileting; total dependence with two staff with transfers and bathing; limited assistance from one staff with personal hygiene; and supervision only with locomotion on and off the unit. Resident #1 was coded in Section M (Skin Conditions) as having two (2) arterial ulcers and having a surgical wound.

Review of Resident #1's hospital discharge summary dated 7/9/21 documented in part, the following: "Chief Complaint: Foul smelling blood blister to right foot...history of spinal cord injury with residual right-sided weakness, currently in acute rehab (other nursing facility at the time), resents (sic) with the above complaint...The patient had started to stand and work with physical therapy at the acute rehab. When at some point in time he bumped his right foot. Over the course of time this led to a red blistering and began to have malodorous smell to it. He subsequently went to this podiatrist (Name) who sent him to the emergency department...Osteomyelitis right foot. Plantar forefoot soft tissue ulceration and evidence of osteomyelitis/septic joint involving the fourth MTP (big toe) joint. Patient surgery by podiatry on 7/2: Amputation of right 4th toe at the MTP (big toe

- 3. Education was provided to licensed staff on the facility Change of Condition process and following. MD/RP orders. Staff to be educated on wound vacs and on call resources for questions they have on using device
- DON or designee will review new MD orders 3 x per week X 4 weeks to ensure all new MD orders have been implemented. Audits will be completed weekly X 4 weeks to ensure residents who are experiencing a change in condition are being identified, assessed, and monitored. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
- 5. DOC 10/3/21

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

		T DELIVIOLO				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/19/2021
PELICAN	HEALTH NORFOLK			827 N	ORVIEW AVENUE FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 00.4	c		1	*	ŧ	
F 684	Continued From page	47	F	684		
	joint), Partial 4th meta	tarsal resection right foot	1			
	and excisional debride	ement of open wound right				
	foot to level of muscle					
		kimately 7 cm x 6 cm x 0.3				
		und vac (1) appliedon	i			
		until August 13thfollow up				
	with Infectious Diseas					
		Follow up with surgeon in 1				
,	weekDischarge Wou	ind VAC. Discharge	i			
	Activity: As per podiat					e e
	please make sure pati					
		th Services: Skilled Nursing	×			
	ONLY Wound VAC: Su	iction frequency:	1,50			
		ction to area of body: right				
		AC suction to 125 mmHg				
		/). Change Wound VAC:				
		00 (9:00 a.m.). Change				
х	Review of Resident #1	's July 2021 admission				
	orders revealed the fol	lowing order was initiated				
	on 7/11/21: "Change w	ound vac every other day				
	at 0900 Suction at 125	mmHg apply wet to dry				
	dressing if wound vac					
	arosonig ir wound vao	not in place.				
	Review of a note from	the physician dated				
	7/11/21 documented in					
		ridement of open wound				
		scle - post debridement				
	measurements approvi	imately 7 cm x 6 cm x 0.3				
	cmon Zosyn until Aug	ruet 12th Wound von				
	appliedfollow up with	Infaction Diseases				1
	podiatrist"	milection disease and				
	Review of Resident #11	s clinical record revealed a				
		are physician on 7/12/21				
	that documented in	t the following "OLL f				
	that documented in par					
	Complaint: Comprehen	sive skin and wound				
	evaluation for new adm	ission to facility for Right	1			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	€1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00000000 to 10				С	
		495309	B. WING			08/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK			827 N	ORVIEW AVENUE		
				NORF	FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	ALC: NO.
E 604	_		10				
F 684	Continued From page		F	684			
	foot fourth toe amputa			*			
		Current conditions: Acute		*			
		kle and footPlan: Wound					
		vearing fleece lined surgical					
	boots. Intravenous (IV						
		oot. PICC (peripherally					
		ter) line (3) to right upper lantar right foot per surgeon					- 1
		w up with surgeon. See					- 1
		mentation for full wound					
		mended nursing plan of					
		sessment and (&) Plan -					-
		Icer noted, discussed case					1
	in depth with staff and						١
		of foot ulcer, hyperglycemia					-
	(high blood glucose) c						-
	wound care dressing r	nanagement. Consults: I					1
		nt and staff today to F/U	4				-
	(follow up) with operat	ing surgeon as ordered."					-
	Review of the wound of	care physician's					
	observations to Reside	ent #1's right plantar foot	1			[ <b>v</b> ]	-
	revealed that measure	ments and a description of					١
	the diabetic foot ulcer						-
	following was docume						١
	"7/12/21Length: 0.00	cm, Width: 0.00 cm,					1
		2, Black: 0.00 cm2, Yellow:	*				1
	0.00 cm2, Pink: 0.00 c						1
	cm2Wound VAC per	surgical orders. Monitor					1
		with surgeonPresent	£				1
	upon admission. Etiolo	gy. Surgical Wound."					
	Review of Resident #1	's July 2021 Treatment					
		(TAR) revealed that staff	ě				
	were implementing the						
		1 when a blank (no staff					
	signature) was noted o						
		o to the sistematical Section (	į.				
	A nursing note dated for	or 7/20/21 documented in	.1.				

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2021 FORM APPROVED

CLITTE	COT ON MILDIOPHIL &	T SERVICES					OMB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONS		(X3) DATE SURVEY COMPLETED		
		495309	B. WING				08/1	9/2021
	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP C PRVIEW AVENUE	ODE	¥	
PELICAN	HEALTH NORFOLK			400000000000000000000000000000000000000	OLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 684	Continued From page	49	F	684			1	
	part, the following: " irregular borders, light removal of sponge. sli stitches upon removal bleeding stopped. tiss (dead tissue) noted. re	wound vac changed. c drainage noted upon ght bleeding noted near c pressure applied x 5min, ue pink with little necrosis emoved canister look new, ttient tolerated treatment		9				
u u	description of what the	e in the clinical record of a right plantar wound had nce directly prior to 7/20/21.				3		
;	the nurse on duty notif	ent order for the necrotic						
	Resident #1's wound v 7/21/21 (the next sche changed on 7/20/21. T	uly 2021 TAR revealed that rac was not changed on duled day) due to it being he following Electronic ) was documented by the lent was provided		*			,	
,	Due to the treatment not 7/21/21 it was also not because this was not a (No treatment was proving).	provided on 7/22/21 scheduled treatment day	6 6					
	necrotic area and sloug the right foot. Area clea	te dated 7/23/21 ing: "Resident noted with gh to the surgical wound on ansed and new order for (5). Resident phoned his						

podiatrist and made an appointment for Monday

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
							С
		495309	B. WING			08/	19/2021
	PROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 604	0		4				
F 684	P-30		F	684			
		:00 pm. Resident also					
		ion. Provider made aware	1				
	of clinical situation."					1	
	The only non-pressure	a wooldy wound					
		Resident #1's clinical record	i				
		ollowing was documented:				İ	
		cal. Location: right foot. Date				i	
	wound noted: 7/1/21.						
		. Drainage: none. Wound					
		h x Width x Depth): 5.2			4		18
	centimeters (cm) x 3.5	x (no depth documented).					
	Description of peri (arc				ž		
	necrotic slough. Descr shape: irregular"	ibe wound edges and	i	Î			
		/26/21 documented the	į				
	following: "Returned fro (appointment), MD (Me						
	replace wound vac. site	e debrided."					
	An after visit summary						
	7/26/21 could not be for						1
	clinical record. Attempt	s were made from this					
	office during the source	om Resident #1's podiatry					
	office would not provide	e of survey. The podiatry					
		musimusuli					
	There was no evidence	of any further missed					
	dressing changes to Re	esident #1's plantar foot					
	wound after 7/23/21.						
	An after visit summer:	obtained from this!t					
		obtained from this writer of and Ankle Specialist (not	i				
	the podiatrist) documen	nted in part the following					
	measurements on 8/9/2	21: "Right fourth incision					
	completely healed. The						
		cm x 0.4 cm in depth. The					
9	wound is 70 percent gra	anular (red healing tissue)					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	I			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	495309	B. WING		08/19/2021	
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH NORFOLK		8	STREET ADDRESS, CITY, STATE, ZIP CODE 327 NORVIEW AVENUE NORFOLK, VA 23509		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 684 Continued From page	E4	j.			
7-3-		F 684			
30 percent fibrotic isla	nds (healing tissue). There				
is no exposed bone or		I S			
	edness) or acute sign of out 4 weeks (9/6/2021)."				
On 9/19/21 at 11:29 -					
On 8/18/21 at 11:38 a.	.m., an interview was				
#2 a purso who works	ed Practical Nurse (LPN)				
#1 frequently I DN #2	ed 7 p to 7 a with Resident				
first time I BN #2 had a	was an agency nurse. The				
plantar wound was an	seen Resident #2's right	u u			
boing placed on "Class	8/6/21 due to the dressing			·	
I DN #2 stated that are	by the day shift nurse.	ē			
LPN #2 stated that on					
	peeping that night indicating				
	LPN #2 stated that nursing				
	nining from the facility on				
know the begins as a li	wound vacs; although she				
knew the basics as a li					
#1's wound as I DN #2	were classifying Resident				
a proscure ulcer Lem	2 stated, "I want to say it is				
a pressure dicer. I am	not entirely sure." When			1	
asked if his wound was					
	ocuments his right plantar			i	
	ne wound care physician				
	al and then diabetic, LPN				
#2 stated again that sh				9	
type of manifering of	were expected to do any				
s resident LDN #2 -t-t	wound that is identified to				
a resident, LPN #2 stat	ed that she didn't know	3			
rogarding wave do but	s policies and procedures			1	
aware on a pight chift -	that she was never made				
of wooldy or bive state	urse to conduct any type				
stated that aha is well	kin assessments. LPN #2				
stated that she is used	to conducting either				
weekly or biweekly skin	assessments at other				
included non-necessity	unds. When asked if this			1	
included non pressure i	ulcers, LPN #2 stated that			1	
it did. When asked the j	purpose of the weekly or			1	
DIWEEKIY SKIN assessme	ents; LPN #2 stated that			1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) I	MB NO. 0938-0391  (3) DATE SURVEY COMPLETED  C  08/19/2021
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH NORFOLK  STREET ADDRESS, CITY, STATE, ZIP CODE  827 NORVIEW AVENUE  NORFOLK, VA 23509  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 694 Octional Forest 50	08/19/2021  (X5)  COMPLETION
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH NORFOLK  STREET ADDRESS, CITY, STATE, ZIP CODE  827 NORVIEW AVENUE  NORFOLK, VA 23509  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 694 Octional Forest 50	(X5) COMPLETION
PELICAN HEALTH NORFOLK  827 NORVIEW AVENUE NORFOLK, VA 23509  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 694 Octional Forest 50	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 694 Octional Formation  NORFOLK, VA 23509  PROVIDER'S PLAN OF CORRECTION PROFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  E 694 Continued France F59	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
F 684 Continued From page 52 F 684	I
F 684	
the number was to see the little of the litt	
the purpose was to ensure healing or to see if the	2
wound was getting worse. When asked if she knew if his wound had deteriorated since his	1
admission into the facility; LPN #2 stated that she	
was not sure that she usually just goes by what	
Resident #1 says. LPN #2 stated that Resident #1	
had told her that nursing staff missed his wound	
vac dressing for a couple of days and that	
necrotic tissue had formed. LPN #2 stated that	,
Resident #1 had to go out to an appointment to	
get the necrotic tissue removed. LPN #2 denied	
seeing any further necrotic tissue when she had	
to redress his wound on 8/6/21.	
On 8/18/21 at 2:00 p.m., an interview was conducted with Administrative Staff Member (ASM) #2, the DON (Director of Nursing). When asked how often wound assessments were conducted on residents with wounds, ASM #2 stated that wound assessments should be conducted by nursing staff weekly. When asked what would be included in a wound assessment, ASM #2 stated that measurements would be obtained and the description of the wound such as signs/symptoms of infection/drainage would be documented. When asked if the same process would be followed for non-pressure wounds, ASM #2 stated that all wounds would be assessed monitored. When asked the etiology of Resident #1's right plantar wound, ASM #2 stated that his wound started at another nursing facility as a diabetic ulcer. ASM #2 was made aware by this writer that the only assessment found to Resident #1's right plantar wound was on 7/23/21 when necrosis was found. ASM #2 stated that he would go look for any other wound assessments. ASM #2 was also shown the assessment from the wound care physician that documented	

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495309	B. WING			08/19/2021	
PELICAN	PROVIDER OR SUPPLIER  HEALTH NORFOLK	4		827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 684	Continued From page	53	T _				
			F	684		1	
	Resident #1's right pla	ntar wound. ASM #2 stated					
	again that she will try	to find documentation					
	especially if it was no	t being followed by the		i.			
		comes in weekly." ASM #2					
		care specialist may have				†	
		because the right plantar					
		al and being followed by a					
		sked if she also expected					
	her nurses to do a wou					6	
	residents coming in wi	th wounds, ASM #2 stated	1				
	that she would expect	the admission nurse who				All	
	was doing all the admi	ssion paperwork to assess			•		
	the wound. When aske	ed the purpose of					
	that the number was t	essments, ASM #2 stated	İ			1	
		monitor and to keep track	* *			}	
	to make sure the woun						
		ecrotic tissue on 7/23/21,					
+	ASIVI #2 Stated that the	day shift nurse had called					
		om because of the necrotic					
		that the nurse informed her					
	his fast because of the	y the wound vac back onto					
		necrosis. ASM #2 stated	e			1	
	vac will not holp the we	ssue is present, a wound ound. ASM #2 stated that a					
	wound vac only works	with good granulation					
		that she obtained an order					
4	for santyl and calcium a		3			h	
		ely made an appointment				1	
	with his ortho podiatrist	for 7/26/24 A SM #2					
	stated that the wound v	vas then debrided at his				9 4	
	annointment on 7/26/24	l and an order to reapply					
		it back with the resident.					
		ng staff knew that a wound				3	
		ed to necrotic tissue, ASM					
		t." When asked if necrotic					
	tissue was present befo					ų.	
	7/20/21 when the nurse		: D				
		to the necrotic tissue, ASM					
		not speak for that nurse					

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0	391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309	B. WING			С	
NAME OF B	ROVIDER OR SUPPLIER	433303	D. WING	_		08/19/2021	
NAME OF F	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK				7 NORVIEW AVENUE		
			All and a second	NO	DRFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	NC
F 684	Continued From page	54	E 4	684		1	
	that she wasn't sure if		F	004			
	looking at necrotic tiss	When esked if all	,				
	nurses were trained o	n wound vacs, ASM #2					- 1
		es were trained on wound		£			
		se majority of staff were					
		se majority of stall were spected nursing staff to					
		one who is familiar with					
	wound vacs if they have	ve questions or did not feel					
	comfortable with wour	nd vacs					
	Tomoradio Will Woul	1d 7d03.		1		v.	
	On 8/18/21 at 2:30 p.n	n., an interview was	ж.		* 5		
	conducted with LPN #	1, an agency nurse who					
	changed Resident #1's						
		r to necrotic tissue being		¥:			- 1
	documented as found	on 7/20/21. LPN #1 stated					
	that on 7/16/21 Reside	ent #1's wound was not					- 1
	necrotic. LPN #1 state	d, "It looked like really good					- 1
	pink tissue." LPN #1 st	ated that there was a little					
	bit of slough present be	ut not nearly what it was on					
	7/23/21. When asked v	what necrotic tissue meant,					
	LPN #1 stated that ned					*	
	tissue. LPN #1 stated t	hat she had heard the					
	resident's dressing cha	inge was missed on one of					
	the scheduled days thr						- 1
	schedule for wound va	c changes. LPN #1 stated					
		is not placed on the last					
	scheduled day (7/21/2	1) prior to 7/23/21 and that					
		c on 7/23/21 when she saw					
		he called the DON and the					
		essment. LPN #1 stated					
		ot work on necrotic tissue					
		s obtained. When asked if					
	she was made aware t						
	documented as necroti						
	stated that she was not						
* 1	stated, "I guess they sh	ouldn't have put the vac					
		asked how often wounds					
i	were assessed by nurs	ing staff, LPN #1 stated					
	that in other nursing fac	cilities she was used to					

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING		C
	PROVIDER OR SUPPLIER  I HEALTH NORFOLK		827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE FOLK, VA 23509	08/19/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 684	doing wound assessm When asked if this wa wounds such as diabe #1 stated that it was. I didn't think nurses did assessments on non- current facility becaus one.  On 8/18/21 at 4:32 p.r. conducted with ASM # were no weekly wound Resident #2's right pla wound was surgical ar outside specialist. ASM was originally a diabet debrided now making wound. When asked h this wound if there are wound, ASM #2 stated wound with dressing of we know when the neo right plantar foot if ther prior to 7/20/21, ASM # made aware of the neo that she expected staff assessment if they not tissue. When asked if a from outside providers Resident #1's medical coordination of care an wound, ASM #2 stated orders back but not neo summary for each visit	nents on a weekly basis. Is true for non- pressure etic, arterial or surgical, LPN LPN #1 stated that she weekly wound pressure wounds at the eash has never had to do and, further interview was #2. ASM #2 stated that there are measurements for an interview of measurements for an interview was the mode being followed by the and being followed by the and being followed by the are wound a surgically the wound a surgically ow staff were monitoring an assessments on the lathat staff look at the hanges. When asked how crotic tissue started to the eare no assessments #2 stated that she was first crotic tissue on 7/23/21 and to get her for an ice changes like necrotic all after visit summaries should be placed on record to help with the did the management of his that they usually get cessarily the after visit	F 684		
	On 8/18/21 at 1:31 p.m interview was attempte documented Resident and precipitation of the control of the contr	d with the nurse who #1's wound as having			

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) E	OATE SURVEY OMPLETED		
		40					С		
		495309	B. WING				08/19/2021		
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE				
PELICAN	HEALTH NORFOLK			827 N	NORVIEW AVENUE				
				NOR	RFOLK, VA 23509				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 684	Continued From page	. EG	_						
			F (	684					
	reached for an interview	ew.		1			*		
	On 8/19/21 at 11:55 a	m an interview was	y				8		
	conducted with ASM #								
	physician. ASM #4 sta								
	allowed to conduct as	sessments on any resident					1		
	that does not have a p	ressure ulcer. ASM #4	38						
		s she is allowed to measure							
	and assess other wou								
	wounds even if the res	sident is being seen by an							
	wound ASM #4 states	second pair of eyes on the I that Resident #1's wound					*		
		abetic ulcer. ASM #4 stated			<b>3</b> 0	18			
	that because his right						1		
j.		the level of the muscle, it							
	was classified as a sur								
	admission into the faci	lity.							
	On 8/19/21 at 2:49 p.n	a. Administrative Staff							
		Administrator, ASM #2,	0 H SS						
	the DON (Director of N		2						
	Regional Director of Cl	inical Services, and ASM							
		e were made aware of the							
		asked ASM #2 if necrosis							
	was documented as be	eing present on 7/20/21 to							
		ed if a new order should	R				,		
		that time, ASM #2 agreed					`		
	was also a delay in trea	n. ASM #2 agreed that this							
	was also a aciay in the	aunent.							
	The only wound policy	that could be provided as a					:		
1	facility policy titled, "Wo	ound Treatment							
	Management" that doc	uments in part, the							
j	following: "To promote	the healing of various							
	types of wounds, it is th	ne policy of this facility to							
		d treatments in accordance					1		
		of practice and physician							
	ordersWound treatme								
i	accordance with physic	ian orders, including the							

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES		OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		495309	B. WING			08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			827 N	NORVIEW AVENUE	
				NOR	RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 684	Continued From page	57		684		
	cleansing method, typ		ļ	004		
		changeThe effectiveness				
	of treatments will be m	nonitored through ongoing				
		und. Considerations for				
	needed modifications					
		ealing. b. Changes in the				<u> </u>
		vound. c. Changes in the references, such as end of				
	life or in accordance w					
3	me et mi describation il	Tall the the rights.				
i	(1) A wound vacuum (	Wound Vacuum Assisted	57			
	Closure) is a device th	at assists in wound closure				
	by applying localized r	negative pressure to draw				œ
		d togetheraccelerates				
	wound healing" This information was o	btoined from		e E		
		ing 6th Edition, Potter &				2
	Perry, 2005. Page 153					
	(2) Zosyn also known			1900		
	piperacillin/tazobactam					
	administered antibiotic					
		ional Institutes of Health. ih.gov/pmc/articles/PMC25				
	04059/.	in.gov/pmc/articles/PMC25				
	3) PICC (peripherally in	nserted central catheter)-				
	Central catheter is a ve	enous access device that				
		the superior vena cava				1
		RA). They can be inserted				
	centrally (centrally inse					1
	through the basilia bas	PICC). PICCs are placed				1
	cubital vein of the arm.	chial, cephalic, or medial				
		onal Institutes of Health.				
		h.gov/books/NBK459338/				
	>					

(4) Calcium Alginate- Alginate dressings are

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

OLIVILI	TOT WILDICANL &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
Approximated an extract extraction	PROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509	1 00.10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
	treatment of moderate partial- and full-thickness stage III-IV pressur surgical incisions, deh wounds, sinus tracts, information was obtain https://www.woundsordressings/alginates.  (5) *SANTYL® Ointmestive enzymatic thera removes necrotic tissur microscopic level. The bed of microscopic cel granulation to proceed occur. ( <http: td="" www.sa<=""><td>primary dressing in the ely to heavily exuding ess draining wounds such e ulcers, dermal wounds, isced wounds, tunneling and donor sites. This ned from urce.com/product-category/ ent is an FDA-approved py that continuously e from wounds at the is works to free the wound lular debris, allowing and epithelialization to ntyl.com/about&gt;)</td><td>F</td><td>684</td><td></td><td></td></http:>	primary dressing in the ely to heavily exuding ess draining wounds such e ulcers, dermal wounds, isced wounds, tunneling and donor sites. This ned from urce.com/product-category/ ent is an FDA-approved py that continuously e from wounds at the is works to free the wound lular debris, allowing and epithelialization to ntyl.com/about>)	F	684		
	and monitor a resident related to a PICC (peri catheter) line for Resid Resident #1 was admit 7/10/21 and readmitted diagnoses that included unspecified open wour complete traumatic amtoe, acute osteomyelitis right ankle and foot, typquadraplegia, and deel lower extremities. Resident Minimum Data Set (ME) admission assessment reference date (ARD) of	pherally inserted central ent #1.  Ited to the facility on a fon 7/26/21 with a but were not limited to a do to the right foot, putation of one right lesser is (bone infection) of the pet two diabetes mellitus, or vein thrombosis of the dent #1's most recent pos) assessment was an with an assessment of 7/10/21. Resident #1 act in cognitive function pole 15 on the Brief				

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405000				С
NAME OF D	ROVIDER OR SUPPLIER	495309	B. WING			08/19/2021
PELICAN HEALTH NORFOLK				827 N	ET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 684	Continued From page	59		684		
	Resident #1 was code (Medications) as recei #1 was coded in Secti			584		
ı	Review of Resident #1 (Physician Order Sum following orders:	I's July 2021 POS mary) documented the	¥	İ		
	Use 3.375 gram intrav	1) 3-0.375 grams (GM). enously every 6 hours for nistrations." This order was 21.	*			
	(unit/milliliter). Use 1 u hours for PICC (3) mai	solution (2) 1 UNIT/ML nit intravenously every 6 intenance. This order was 11. This order was changed of 7/23/21.				
	discussed his concern the beginning of his stafflushing, clamping and Resident #1 had stated 7/23/21, the 7 am to 7 not identify forgot to classesident #1 stated as a	nt #1. Resident #1 had that he didn't feel like in ay, staff were properly monitoring his PICC line. I that on the evening of pm nurse; who he could amp his PICC line. I result of this incident, a had come out of his line ed, siderail and floor. If the first incident is the property of the line and come out of his line and come out of his line and floor. If the property is the line and floor. If the property is the line and floor. If the property is the line and floor. If the line is the line is the line and floor. If the line is the line i				
1	Review of Resident's # no documentation rega 7/23/21; 7 a.m. to 7 p.n					

	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 09	38-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SUR'	
		495309	B. WING			С	
NAME OF P	PROVIDER OR SUPPLIER	43303	B. WING	_		08/19/2	021
	NOVIDER OR SOFFEIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK				27 NORVIEW AVENUE		
	1			N	ORFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) MPLETION DATE
F 684	Continued From page	60	-	C0.4			
		1's care plan dated 7/25/21	Г	684			
2	documented in part th	ne following: "(Name of	1				
	Resident #1) has note	ntial for infection related to					
		to blood r/t (related to)					
	PICC IVMonitor for h						
	dislodgement of cathe	ter, broken or disconnected					
	lines. Report any abno physician"		2				
	Further review of Resident	dent #1's clinical record					
· i		ere obtained on 7/23/21 at			g g		
	2:02 p.m. The following	g was recorded: BP (blood					
*		nhg; 67 beats per minute,					
		ygen saturation. No further					1
	vital signs were record	ed for 7/23/21.					1
	A nursing note dated 7	/23/21 night shift, (7 p.m.					
	to 7 a.m.) documented	in part, the following:					
	"Continues IV Pip/Tazo						
	adverse reactions. dou						
	(Right Upper Extremity						
		and symptoms) of irritation					
	or infection noted. bloo	d noted to bedsheets, per					1
	patient site was bleedir	ng earlier. this nurse					
	insisted on changing sh	neets more than once,					- 1
	patient declined multipl	e times."	£				
	Further review of Resid	lent #1's clinical record					
		ences of bleeding from his	j .				1
	PICC line. There was n	o evidence of any					
	bleeding from his PICC					4	
			5 9				
,	There was no evidence	of an assessment done					
	on Resident #1 regardi						
	follow-up assessments						
	A physiciant !!	and has formed to Do the st	*				
,	m priysician note could i	not be found in Resident					- 1
	#1 5 cliffical record rega on 7/23/21.	ording the above incident	8				
,							

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			С
NAME OF P	PROVIDER OR SUPPLIER	100000		STRE	TET ADDRESS OF STATE 710 CODE	08/19/2021
	HEALTH NORFOLK			827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From page	61	FI	684		,
	Nurse (LPN) #1, the n 7/23/21 7 a to 7 p shift recall an incident when coming out of his PICC over his bed, bed rail at that this had happened stated that she could resaw the blood but that floor, bed rail and on hwas a large amount of his PICC line. LPN #1 sure if this had happened to 7 a and she walker rounds or if it had happened was not quite sure bed rounds may have beer rounds may have beer sure when the recall and the recall that happened to the recall that happened to the recall that happened the recall that happened the recall that happened the recall that happened the recall that happened that happened the recall that happened that happened the recall that happened that happened that happened the recall that happened the recall that happened that happe	ted with Licensed Practical nurse who worked on ft. When asked if she could bre Resident #1's had blood C line and had leaked all and floor, LPN #1 stated and on one occasion. LPN #1 not recall the exact time she to the blood was dried on the his sheets. LPN #1 stated it follood that had leaked from stated that she was not ned on the previous shift 7 ed into his room on her first pened on her shift. LPN #1 cause she stated her first n late. LPN #1 did not recall	3 4			
	the resident's bed, floo that she recalled clean bleach from the floor a she assessed the PICO clamped at that time. L PICC line was not active	and rail. LPN #1 stated that C line and stated that it was	a.	2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		i e
	the line with normal sa with the flush. LPN #1 was also had no change anything that would ale change in condition. LF bleeding may have been that were scheduled expordered for PRN (as no had documented her as	aline and she had no issues stated that Resident #1 ges to his mental status or ert her that he was having a PN #1 stated that the en from the Heparin flushes very shift and now were eeded). When asked if she issessment in the clinical		60 cm		
	record, LPN #1 stated to clinical record then she					

assessment. When asked if she had notified the

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

		I SERVICES				OMB NO. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		405000				С
NAME OF B	ROVIDER OR SUPPLIER	495309	B. WING			08/19/2021
I WANE OF F	NOVIDEN ON SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK				NORVIEW AVENUE	
	0.0000000000000000000000000000000000000			NOR	RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 684	Continued Faces	00		ď		
1 004	Continued From page		F6	884		
	did not because the B	ent, LPN #1 stated that she esident was not having any	ų T			
	changes in his condition	on. LPN #1 stated that she	ř.			
	kept checking on the r	esident to see if he had any				
	changes. When asked	what checking entailed,	3			
		uld pop in his room and				
	check in on him. When	n asked if vital signs were				
		ne discovered the blood or				
		ng, LPN #1 stated she just				
	looked at the vital sign	s triat were aiready shift by the CNA (Certified	2			
	Nursing Assistant). Wh					
5		lushes were in response to			4	
	the bleeding episode of	n 7/23/21, LPN #1 stated		7		
	that she thought that n	nay have already been an	¥			
	order prior to the incide	ent.				
	On 8/19/21 at 2:49 p.m	., Administrative Staff				
	Member (ASM) #1, the	Administrator, ASM #2,				
	the DON (Director of N	ursing), ASM #3, the				
	He the corrector of Cl	inical Services, and ASM				
	above concerns.	e were made aware of the				
	above concerns.					
	(1) Zosyn- also known	as Tazocin®				
	piperacillin/tazobactam	is an intravenously	1			
	administered antibiotic.		•			<u>4</u> 6
		onal Institutes of Health.		1		
	nttps://www.ncbi.nlm.ni 04059/.	h.gov/pmc/articles/PMC25				
	040397.					
	(2) Heparin Lock Flush	- Heparin flush belongs to		Į.		
	the family of drugs calle	ed anticoagulants. This is	i			
1	used to prevent blood f	rom clotting or "stopping	3			
	up" your intravenous (I\	/) line. Heparin, in the				
	doses used to flush IV	ines, should not normally				a .
	keep your blood from c	otting elsewhere in your				
1	body. This information	was obtained from				1
	nups.//cookcillidielis.or	g/SiteCollectionDocument				

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		MEDICAID SERVICES			<u> </u>	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		STRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/40/2024
NAME OF P	ROVIDER OR SUPPLIER			STREE1	T ADDRESS, CITY, STATE, ZIP CODE	08/19/2021
PELICAN	HEALTH NORFOLK		1		PRVIEW AVENUE	
LLIOAN	TIEAETH NORFOLK			NORFO	OLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684	Continued From page	63	Г 60	,		
	- Tompo	ion/InfusionTherapy/CCHH	F 68	4		
	Infusion Heparinand	SodiumChlorideFlush.pdf.				
		e da la la la la la la la la la la la la la				
	(3) PICC (peripherally	inserted central catheter)-				
	Central catheter is a v	enous access device that				
		n the superior vena cava				
	(SVC) or right atrium (	RA). They can be inserted				
	centrally (centrally inse	(PICC). PICCs are placed				
	through the basilic, bra	achial, cephalic, or medial				
	cubital vein of the arm	. This information was				8
		ional Institutes of Health.	¥.			0
	https://www.ncbi.nlm.n	ih.gov/books/NBK459338/			•	
	3. The facility staff faile	ed to administer medication				к
	for nerve pain on 7/26/	21; scheduled insulin on				
	8/2/21; and sliding sca Resident #1 per physic	ie insulin on 8/6/21 for				
	Resident #1 was admit	ted to the facility on				
	7/10/21 and readmitted					
	unspecified open wour	d but were not limited to				
		putation of one right lesser				
		s (bone infection) of the				
		pe two diabetes mellitus,				
	quadraplegia, and deep	vein thrombosis of the				
	lower extremities. Resi					
	Minimum Data Set (MD	OS) assessment was an				
	admission assessment reference date (ARD) c					
		act in cognitive function				
	scoring 15 out of possit					
	Interview for Mental Sta					
	Resident #1 was coded	I in Section N				1
	(Medications) as receiv	ing insulin injections.				
						1

On 8/17/21 at 10:55 a.m., an interview was

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CEITTE	TO TOT MEDICARL &	WEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
	PROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509	1 33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 684	Continued From page	64	F	684		3
		ent #1. Resident #1 stated	•	001		1
						k
	for his days and also	medication for nerve pain				
	for two days and also	that facility staff sometimes				,
		od sugar or give him insulin				į
	prior to his meals. Res	sident #1 stated he				
	sometimes misses his	scheduled insulin				
	injections.					
	Review of Resident #1	's July 2021 orders	×			, E
	revealed the following	medication for nerve pain:				
	"Gabapentin (1) Table	t 600 mg (milligrams) Give			<b>⊕</b>	3
	1 tablet by mouth two	times a day for pain "				
	in Since of investment and			1	S.	
	Review of the narcotic	logs for Gabanentin				*
	revealed that 30 tablet	s arrived to the building on				
	7/12/21 from pharmac	The sount went to 0	3			
	(zero) on 7/26/21 at 9:					
	60 tablets were sent to	arcotic logs revealed that the building on 7/27/21.				
	on 7/28/21 at 9:00 a.m	ered from this pack was				
	Further Review of Res revealed that staff door					
		pentin on 7/26/21 at 5 p.m.				
			e e			
	and 7/27/21 at 9:00 a.r	n. and 5 p.m.				
	Review of the emerger that Gabapentin 300 m	ncy STAT box list revealed				
	medication in the STAT					
	medication in the STAT	DUX.				
	pharmacy revealed that accessed the STAT botton 7/27/21 for both the shifts. 2 tablets were purchased that the shifts are tablets as no evidence that the shifts are tablets were purchased to the shifts.	ulled to equal 600 mg. that staff attempted to				
	access the emergency	STAT box list on 7/26/21				1

CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES				OMB NO. 0938-0391	ı
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309	B. WING			C 08/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2021	-
DELICAN	UEALTH NODEOLK			827 N	ORVIEW AVENUE		
PELICAN	HEALTH NORFOLK			NOR	FOLK, VA 23509		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		1			4
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 684	Continued From page	65	F.	584			
	at 5 p.m.			JO-T			I
	at o pilli						ı
	There was no evidence	e that Resident #1					١
		or negative outcomes on					I
	7/26/21 when his Gab	apentin was missed x 1					١
	dose.			-			١
:							l
	On 8/18/21 at 12:53 p.						l
		Staff Member (OSM) #6 the		į.			ı
		#6 confirmed that the only					١
	was on 7/27/21 OSM	o access the STAT box #6 stated that staff did not					l
*	access the STAT box of			8	a a		l
	access the STAT BOX (	JII 1120/21.					l
	On 8/18/21 at 1:31 p.m	and 4:22 n m an					l
	interview was attempte	ed with the nurse who failed					١
	to administer the Gaba	pentin on 7/26/21 at 5 p.m.					ı
	She could not be reach	ned for an interview.					
	Review of Resident #1	's August 2021 POS					
		t) revealed the following					ı
	insulin orders:						
	"Admelog SoloStar Sol	ution Pen Injector (2) 100	u.				
		ubcutaneously with meals					
	for DM (Diabetes Mellit						
	"Admolog SoloSter Cel	ution Don Interter 400					
	"Admelog SoloStar Sol	ution Pen Injector 100 (1 Unit Dial) Inject as per				1	
	sliding scale; if	(1 Onit Dial) inject as per					
	201-250 = 2 units;						
	251-300 = 4 units;		×				
	301-350 = 6 units;						
	351-400 = 8 units;						
		ot resolved in 2 hours, call					
		ubcutaneously (under the					
	skin) before meals and	at bedtime for diabetes,					
1	ow blood sugar."						

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 09	38-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURV COMPLETE	
		495309	B. WING			C 08/19/2	N21
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2	021
PELICAN	HEALTH NORFOLK				NORVIEW AVENUE		
				NOF	RFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	(X5) MPLETION DATE
F 684	Continued From page	66	E (	684		1	
		1's August 2021 MARs	1 (	J04 .			
	revealed that his sche	duled insulin was missed		,			
		Resident #1's sliding scale					
		ar check was not completed					
		30 p.m. Resident #1's blood					
	sugar was documente			i			
	glucose check on 8/2/	21 at 10:00 p.m.					
	Further review of Resi	dont #1's August 2021	9				
		missed his sliding scale					
	insulin on 8/6/21 at 11		·			•0	
		imented: "PATIENT HAD	) ×			el el	
	and sliding scale insuli	o administer the scheduled in on 8/2/21 and 8/6/21 had and could not be reached		ä			
q	nurse who worked 7 p frequently. When aske	ed Practical Nurse #2, a to 7 a with Resident #1					
	no signatures meant th	ne medication was not					
	given. When asked if F	Resident #1 had ever made					
	her aware that the 7 a						
	administer insulin, LPN						
	recall the resident mak	ing her aware of that. LPN					
		e who failed to administer					
	recalled that he was slo	ly passed away but she					
		not have had the time to do					
		nd administer insulin before					1
	the resident's meals. W	hen asked if she ever					
		aving a high blood sugar					- 1
		lin being missed the shift					
	prior, LPN #2 stated that						
	When asked if a blood						

	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		405200	D 14/11/10			С
NAME OF F	PROVIDED OF CURRY IED	495309	B. WING			08/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			827 N	IORVIEW AVENUE	
				NOR	FOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From page	67	F	684		
		_PN #2 stated, "That is	F	004		
		hen asked if the physician				
		e of any missed medication,				
	LPN #2 stated that the	physician should be made				
		uld be documented of all				
	missed medications.					
	On 8/19/21 at 2:40 n n	n., Administrative Staff				
		Administrator, ASM #2,				i I
	the DON (Director of N	Jursing), ASM #3, the				<i>u</i>
	Regional Director of C	linical Services, and ASM	4	1	×	
×.	#5, the corporate nurs	e were made aware of the	. 3			
	above concerns.					
	F04					
		ledication Administration" following: "Medications are	1			
	administered by licens	ed nurses, or other staff				
	who are legally authori	zed to do so in this state,				ž.
	as ordered by the phys	sician and in accordance				
	with professional stand	lards of practice in a				
	manner to prevent con					
	infectionAdminister n	nedication per order"				
	Facility policy titled, "M	adjection Errors"				
	documents in part, the	following: "The facility				
- 1	will consider factors in	medication administration,				
	including but not limited	to, the following: "a.				
	Medication administered	ed not in accordance with				
	the prescriber's order. I					
		nissionIf a medication				
	error occurs, the follow					
		assesses and examines and notifies the physician				
		ner as soon as possible"				l
	- I I I I I I I I I I I I I I I I I I I	as coon as possible				
	(1) Gabapentin is comm	nonly used to treat				
	neuropathic pain (pain	due to nerve damage).				
		otained from the National				1
	Institutes of Health.					

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391	1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309	B. WING			C 09/40/2024	
NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	08/19/2021	4
PELICAN	HEALTH NORFOLK			827	NORVIEW AVENUE		
				NOF	RFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 684	Continued From page	68	F f	684			1
	, =	lm.nih.gov/28597471/.	;	<b>70</b> T			
	rapid-acting human in improve glycemic compatients 3 years and complitus and adults with This information was constitutes of Health. https://dailymed.nlm.nm?setid=0691def8-4a1.	Solution Pen Injector- is a sulin analog indicated to trol in adults and pediatric older with type 1 diabetes th type 2 diabetes mellitus. Obtained from The National ih.gov/dailymed/drugInfo.cf 7b-4de3-866f-a280989f47f					
	Resident #3 was admi 10/6/20 with diagnoses limited to type two diable depressive disorder, at Resident #3's most red MDS (assessment) was with an Assessment Resident #3 was impaired in cognitive for possible 15 on the Brie Status (BIMS) Exam.	s that included but were not betes mellitus, major and high blood pressure. Sent Minimum Data Set as a quarterly assessment eference Date (ARD) of as coded as being severely unction scoring 06 out of af Interview for Mental		ř			
	was alleged that reside	nents on 12/26/20 night				i i	
	Review of Resident #3 Medication Administrat 9/26/20; revealed that I						

		MEDICAID SERVICES				OMB NO. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
NAME OF B	PO//IDED OD 0/ IDEA / IDE	495309	B. WING			08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK				7 NORVIEW AVENUE	
				NO	DRFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 684	Continued From page	69	F	684		
	following ordered med	lications at 9 p.m.:				
	1) "Atorvastin Calcium (milligrams) Give 1 tal	n (Lipitor) 40 mg olet by mouth at bedtime for	1			i
	high cholesterol. 2) Melatonin Tablet Gi	ve 6 mg by mouth at				
		ive 1 tablet by mouth at	ī			
	bedtime for depression 4) Trazadone HCl Tab	let 50 MG Give 1 tablet at				
	bedtime for depression 5) Metformin HCL 500 two times a day for dia	MG Give 1 tablet by mouth	in the second se			
	MAR revealed that he blood sugar check and following order was do			*		
	sliding scale: If 150-199 = 2 units giv	sulin Lispro) Inject as per				i
	200-249 = 4 units give 250-299 = 6 units give	4 units; 6 units;				
	300-349 = 10 units give 350-399 = 12 units 12 400 - 450 = 14 units 14	units;				
1	subcutaneously three t	imes a day for diabetes al Doctor) if blood sugar is				
	revealed that his next b	a.m., where he read at a				
i	There was no evidence any negative outcome missed medications.	e in his clinical record of related to the above				

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		495309	B. WING			08/19/2021
	ROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE RFOLK, VA 23509	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	7	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION
F 684	Continued From page	70	F 6	884		
	Nursing (DON.) The I reviewed with the DOI expected staff to admi ordered by the physicishe was not employed December and was not were not administered On 8/19/21 at 2:49 p.m Member (ASM) #1, the the DON (Director of Negional Director of C	ted with the Director of December 2020 MAR was N. The DON stated that she nister all medications as an. The DON stated that I with the facility in of sure why the medications on., Administrative Staff e Administrator, ASM #2,				
	5. Facility staff failed to medications per physic on 12/26/20.	o administer all 9 p.m. cian's order to Resident #4				
	limited to non- traumati blood pressure, high of depression, and glauco recent Minimum Data Swas an annual assess Reference Date of 6/4/coded as being intact in 15 out of possible 15 of Mental Status (BIMS) E	s that included but were not ic brain dysfunction, high nolesterol, dementia, oma. Resident #4's most Set (MDS) assessment ment with an Assessment 21. Resident #4 was a cognitive function scoring in the Brief Interview for	a			
, i	was alleged that reside	nts did not receive nents on 12/26/20 night				

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
							С
		495309	B. WING_				08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH NORFOLK		1	827 N	ORVIEW AVENUE		
				NOR	FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ζ	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	71	; F6	84			0
	Resident #4. She coumedications on 12/26, not recall not having a Review of Resident #3 Medication Administra 9/26/20; revealed that following ordered medication and the following ordered medication (milligrams) Give 1 tablished the following that high cholesterol.  2) Lantanprost 0.005 Shoth eyes at bedtime following ordered to Maj 3) Remeron 30 MG Gibedtime related to Maj 4) Tylenol 8 hour Tables MG Give 2 tablets by pain related to LOW B	B's December 2020 Ition Record (MAR) for Resident #4 missed the lications at 9 p.m.:  I (Lipitor) 20 mg Dolet by mouth at bedtime for (percent) Instill 1 drop in					
	Further review of Resigner revealed no negative of above medications not On 08/19/21 at approxinterview was conducted Nursing (DON.) The Dreviewed with the DON expected staff to admir ordered by the physicial she was not employed	imately 9:10 a.m., an ed with the Director of December 2020 MAR was al. The DON stated that she nister all medications as an. The DON stated that with the facility in t sure why the medications					
	On 8/19/21 at 2:49 p.n	n., Administrative Staff					

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495309	B. WING_				C 08/19/2021
	ROVIDER OR SUPPLIER  HEALTH NORFOLK		,	827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE RFOLK, VA 23509		5071372021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	Member (ASM) #1, the the DON (Director of I Regional Director of C #5, the corporate nurse above concerns.  6. The facility staff fair orders to administer A Trazadone and Nifedig Resident #5. Diagnos but not limited to Hyper Hypertension.  Resident #5's Minimur assessment protocol) with an Assessment protocol with an Assessment R coded Resident #5's E Status (BIMS) scored of 15 indicating no cog Resident #5's person-revision date 12/17/20 risk for complications r pressure. The goal: wi complications r/t my hi intervention/approache included: please give r physician/nurse practitions.	e Administrator, ASM #2, Nursing), ASM #3, the Binical Services, and ASM we were made aware of the Bed to follow physician tarvastatin Calcium, poine as ordered for his for Resident #5 included erlipidemia, Insomnia and a quarterly assessment reference Date of 07/09/21 for finite Interview for Mental a 15 out of a possible score unitive impairment.  Dentered care plan with a documented resident is at related to (r/t) high blood II remain free from any gh blood pressure. One set to manage goal me medication as my ioner ordered.	F6	584			
	Administration Record revealed the following Atarvastatin Calcium to by mouth at bedtime for Trazadone 50 mg - give at bedtime for (insomnigive 1 tablet by mouth	ablet 10 mg - give 1 tablet or (hyperlipidema), e 0.5 mg (25mg) by mouth ia), Trazadone 50 mg - at bedtime for (insomnia) ed Release (ER) - give 60					

Further review of the December 2020 MAR,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495309	B MING				(	С	
	PROVIDER OR SUPPLIER HEALTH NORFOLK	433303	B. WING	827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509		08/	19/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE	
F 684	revealed evidenced the nurse; indicating the nurse; indicating the nurse of administered on 12 on 08/19/21 at approximaterview was conduct Nursing (DON.) The Experience of the DON here in December 2022 nurses to administer at the physician."	rere were no initials by the mentioned medications were 2/26/20 at 9:00 p.m.  Eximately 9:10 a.m., an ed with the Director of December 2020, MAR was N, who stated, "I was not 0, but I expect for the II medication as ordered by	F	684					
	Administrator, Director on 08/19/21 at approxi Administration team w	was conducted with the of Nursing and Cooperate mately 3:30 p.m. The ere informed of the above primation was provided prior					8		
	Medications are admin or other staff who are I in this state, as ordered accordance with profes	nplemented (11/01/20.) istered by license nurses egally authorized to do so d by the physician and in		٠					
	to administer (Albutero ordered for Resident # originally admitted to no	ursing facility on 05/24/19. #11 include but not limited nronic Obstructive OPD.)							
	assessment protocol) a							1	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0	938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		v =				С	
		495309	B. WING			08/19/	2021
	ROVIDER OR SUPPLIER HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE C	(X5) COMPLETION DATE
F 684	Continued From page	74	F	584			
9	with an Assessment R	deference Date (ARD) of ent #11's Brief Interview for scored a 15 out of a		<b>J</b> 04			
	care plan with a revision documented resident to exacerbation and responding more spiratory distress surported to show symptoms of being some of the intervention of the include: give mental by my physician/nurse mental for adverse effects	with COPD and at risk for iratory distress. The goal:  y signs or symptoms of ch as restlessness, rackles, tachycardia or ng cyanotic (turning blue).  on/approaches to manage my medications as ordered practitioner and monitor and/or effectiveness of my t adverse effects to my		1			
	Nebulization Solution (inhaler orally twice a direview of the April 2020 there were no initials be mentioned medication 04/10/20 at 4:00 p.m.  On 08/19/21 at approximaterview was conducted Nursing (DON.) The Areviewed with the DON	(MAR) for April 2020, order: Albuterol Sulfate 0.63 mg/ml - one vial ay for COPD. Further 0 MAR, revealed evidenced by the nurse; indicating the was not administered on mately 9:10 a.m., an ed with the Director of					
;	administer all medication physician."						

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

		I SELVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING		C 08/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/13/2021
				STEP OF THE STATE	
PELICAN	<b>HEALTH NORFOLK</b>			827 NORVIEW AVENUE	
				NORFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
F 684	Continued From page	75		604	
			Γ.	684	
	A pre-exit conference	was conducted with the			
	Administrator, Directo	r of Nursing and Cooperate	i		
	Administration to an a	imately 3:30 p.m. The		9	
		vere informed of the above			
	to exit.	ormation was provided prior	r r		ä
	to exit.		i	î	
The facility's policy t		ad: Madiastics			
	The facility's policy titled: Medication Administration - date implemented (11/01/20.)				
Medications are administered by license nurses or other staff who are legally authorized to do so					
		d by the physician and in			٠
	accordance with profe	scional standards of			
		o prevent contamination or			
	infection.	o provent contamination of			
	Compliant deficiency				
F 727	RN 8 Hrs/7 days/Wk, I	Full Time DON	F 727		
SS=E	CFR(s): 483.35(b)(1)-(	3)			1
	(-), (-), (-), (-), (-), (-), (-), (-),	-,	1.	No immediate correction can initi	ated be completed
	§483.35(b) Registered	nurse		for this area.	
	§483.35(b)(1) Except v		2	A TELEVISION	
	paragraph (e) or (f) of		۷.	All residents have the potential to	be affected by this
	must use the services	of a registered nurse for at		deficient practice.	
		urs a day, 7 days a week.	3.	Daily and weekly staffing schedule	es will be reviewed
		, , , , , , , , , , , , , , , , , , , ,		by DON and Administrator to ensu	
	§483.35(b)(2) Except v	vhen waived under		staff coverage. Building will work	'
	paragraph (e) or (f) of t	this section, the facility			
	must designate a regis	tered nurse to serve as the		staffing to assist in providing RN co	overage where
	director of nursing on a			needed.	
	,, ,, ,,		4.	BOM will audit payroll reports to e	ensure all RN hours
	§483.35(b)(3) The dire	ctor of nursing may serve		are captured in the payroll system	
		when the facility has an		will be reported monthly to the Q	
		cy of 60 or fewer residents.			
		is not met as evidenced		The QAPI committee is responsible	e for the on-going
	by:			monitoring for compliance	İ
		nation obtained during the	5.	DOC 10/3/21	
		, staff interview and facility			

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

array man		I OLIVIOLO				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			C 08/19/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/13/2021
PELICAN HEALTH NORFOLK				827 N	IORVIEW AVENUE FOLK, VA 23509	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		DECMEDIO DI ANI OS CODESTADO	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 727	Continued From page	76	_	727		
	р-3-			121		
	Registered Nurse (RN	cility staff failed to staff a				
	Nurse/Supervisor) for	at least 6 consecutive				
	hours a day, 7 days a	week.				
	The findings included:					
	The facility staff failed	to stoff a DN Charre				
	Nurse/Supervisor, for		į			
	hours on 12/26/20, 07	/10/21 07/24/21 and				
	08/07/21.	110/21, 07/24/21 and				
×	00/07/21.			e	90	
	A ravious of the facility		1		-	
	A review of the facility	as-worked staffing on				
		ntation during a 60-day				
		nurses worked 12 hours				*
	shifts (7a-7p) and (7p-	/a.)	É			
	1.) On 12/26/20, RN #	1 worked 4 00 hours				
	(entered the facility at	7:00 p.m.)				
	(	. 100 р.п)	i			
	2.) On 07/10/21, RN #	1 worked 4 25 hours				
	(entered the facility at					
	(entered the radiity at	5.46 p.m.)				
	3.) On 07/24/21, RN #	1 worked 4.25 hours				
	(entered the facility at 6					
	•	,				
	4.) On 08/07/21, RN #1	worked 4.25 hours				
	(entered the facility at 6					
	,,,,,,,,,	р,	i			
	A interview was conduc	cted with the Director of				1
	Nursing (DON) on 08/1	9/2021 at approximately				
	9:10 a.m. When asked	l about the facility act	*			
	having 8 hours of RN c	overage on 12/26/20	ļ			
	07/10/21, 07/24/21 and					ļ
		verage 8 hours and day,				
	every day."					
	A pro ovit oppform	ion annihilatad 2011 U				
	A pre-exit conference w	vas conducted with the				
	Auministrator, Director	of Nursing and Cooperate				1

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

PRINTED: 08/31/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0.001.00			OMB NO. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER	40000	D. WIIIO			08/19/2021
NAIVIE OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			827 N	NORVIEW AVENUE	
				NOR	RFOLK, VA 23509	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID			
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI	ATE DATE
					DEFICIENCY)	
				1		
F 727	Continued From page	77	F	727		
	on 08/19/21 at approx	imately 3:30 p.m. The	5,			
	Administration team w	ere informed of the above	7			
		ormation was provided prior				
	to exit.	ormation was provided prior				
	to exit.					
	Compliant deficiency					
E 760		Cianiferant Maria		1		
1 700 99-D	Residents are Free of	Significant Med Errors	F	760		
33-D	CFR(s): 483.45(f)(2)					
	The facility must assure	en that it-				
	The facility must ensur					·
		s are free of any significant			*	2
	medication errors.					
		is not met as evidenced				
	by:					
	Based on clinical reco	rd review, staff interviews,				
		tion review the facility's				1
	staff failed to ensure 2	of 11 residents (Resident				
	#5 and Resident #1) in	the survey sample was				1
	free from significant me					
	The findings included:				*	
	9 00.5					
	<ol> <li>The facility staff faile</li> </ol>	ed to ensure a significant		X		
	medication (Lantus inst	ulin) was administered on				
	12/26/20 for Resident #	5. Diagnosis for Resident				
		ted to Type II Diabetes.				
		,,,				
	Resident #5's Minimum	Data Set (MDS - an				
	assessment protocol) a	quarterly assessment				
	with an Assessment Re	eference Date of 07/09/21		7		
	coded Resident #5's Br					
		15 out of a possible score				
	of 15 indicating no cogr	nitive impairment				
	g 110 00g1	impairmont.				
	Resident #5's person-c	entered care plan with a	*1			
	revision date 12/41/10	documented resident is an				1
		etic. The goal: will remain				1
	adequate glucose level	s and experience no				
		dia experience no				1

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

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ON ON						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495309	B. WING		C 08/19/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN HEALTH NORFOLK			827 NORVIEW AVENUE			
			NORFOLK, VA 23509			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			

#### F 760 Continued From page 78

signs/symptoms (s/s) of hypo/hyperglycemia episodes. One intervention/approaches to manage goal included: please give me medication as ordered.

During the review of Resident #5's Order Summary Report for December 2020 revealed the following medication order: Insulin Glargine Solution - inject 40 units subcutaneously at bedtime for Type II Diabetes starting on 10/19/20.

Further review of the December 2020 MAR, revealed evidenced there were no initials by the nurse; indicating the mentioned medication above was not administered on 12/26/20 at 9:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The DON reviewed the MAR for December 2020. After she reviewed the MAR, the DON stated "I was not here in December 2020, but I expect for the nurses to administer all medication as ordered by the physician."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled: Medication Administration - date implemented (11/01/20.) Medications are administered by license nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

#### F760

- 1. Medication Lantus insulin failed to be administered to Resident #5 on 12.26.20. Medication Dose was administered on 12/27/20. Resident #5 was monitored to ensure no signs/symptoms of hypo/hyperglycemia episodes. Resident #1 was administered incorrect IV antibiotic Cefazolin on 7/21/21. Correct IV antibiotic Zosyn was administered on 7/22/21. Diphenhyramine HCl Tablet (Benedrayl) was also administered by mouth on 7/22/21. Resident #1 was monitored for adverse signs and symptoms, and no adverse reaction was observed.
- 2. All residents have the potential to be affected from this deficient practice.
- Education was provided to all licensed nursing staff on medication administration to include the five rights of medication administration.
- 4. DON or designee will conduct med pass observation on five residents 3X per week x 4 weeks to verify correct medications are being administered. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
- 5. DOC 10/3/21

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		40.000				С
	College Williams	495309	B. WING			08/19/2021
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH NORFOLK				827 N	EET ADDRESS, CITY, STATE, ZIP CODE NORVIEW AVENUE RFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 760	Continued From page	79	F	760		
	Complaint deficiency					
	free from a significant administered the incor antibiotic to Resident and Resident and Resident and Resident and Resident and Resident and Resident and readmitted diagnoses that include unspecified open would complete traumatic and toe, acute osteomyeliticankle and foot, type two quadraplegia, and deel lower extremities. Resident and Resident Resident and Resident Resid	trect intravenous (IV)  If 1 on 7/21/21.  Itted to the facility on Id on 7/26/21 with Id but were not limited to Ind to the right foot, Inputation of one right lesser Is (infection) of the right Individual odiabetes mellitus, Inputation of one right lesser Is (infection) of the right Individual odiabetes mellitus, Inputation of one right lesser Is (infection) of the right Individual of t				
; ;	nfection for 150 admin discontinued on 8/12/2	nously every 6 hours for strations." This order was				

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1		MEDICAID SERVICES				OMB NO. 0938-039	91
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		saled thouse are a				С	
		495309	B. WING			08/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP COL		
PELICAN	HEALTH NORFOLK			827 N	ORVIEW AVENUE		
				NORE	FOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION EAPPROPRIATE DATE	
F 760	Continued From page	80	i F	760			
	the following nursing i	note dated 7/21/21: "Upon n to give his PM (night) ABT		700			
	(antibiotics) IV (Intrav	renous), this nurse noticed a f another resident) hanging	ř				
	on (Name of Resident	#1's) pole empty. This	:				
	nurse asked him (residue) DON (Director of Nurse	dent) His name and called ing) & on-call (Name of					
	physician group) Long	Term Care left message,					
	(Name of NP) gave a	for NP (Nurse Practitioner) V/O (verbal order): to					
	continue his regular so	cheduled ABT (IV)		800 D			
		r him for adverse reactions and notify ASPA (sic) if	4			as as	
3		ssment given, neuro wnl					
	(within normal limits),						1
	Auscultate), vs (vital si 97.1,98% RA (Room A						
	discomfort issues."	, , , , , , , , , , , , , , , , , , , ,					
	Review of a medication						
		nted the following: "Upon too (sic) give PM ABT IV,					١
		(Name of other resident):					
	Cefazolin (2) hanging	on (Name of Resident #1)					
	's IV pole empty."						
		t 4:15 a.m. documented in					
	part, the following: "Sta	aff has QHRS (hour) adverse reactions, he has					
	verbally stated, "No, I f	eel fine." I will let yall (sic)					1
	know if anything chang	es. VS (vital signs) wnl ,					1
	lungs CTA, skin dry & i rashed, irritation noted.	ntact w/o (without) any					
	The next noted dated 7						
	documented in part, the	e following: "Resident s ABT IV bag , denies any					
		rerse reactions noted, skin					

w/o any rashes/ irritation."

OLIVILI	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		495309	B. WING			08/19/2021
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH NORFOLK			827 NO	ORVIEW AVENUE	
ILLIOAN	HEALITI NON OLK			NORF	OLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 760	Continued From page	81	F	760		5
	Further review of Resirevealed an order date the following: "Diphen 25 MG (Benedrayl) Gi every 8 hours as need Review of Resident #1 that Benedrayl was ad 10:29 p.m. The followifrom med (medication). There was no other inshad to be administered On 8/18/21 at 11:22 a. conducted with LPN (L#3, the nurse who saw had been administered 7/21/21. LPN #3 stated p.m. to 7 a.m. shift. LP walked into the resider #1 his night dose of his empty bag still hanging stated that she noticed resident name on it an	dent #1's clinical record and 7/22/21 that documented hydrAMINE HCI Capsule (3) we 1 capsule by mouth led for allergies for 7 Days."  I's clinical record revealed ministered on 7/22/21 at ng was documented: "rash error."  Stances where Benedrayl f.  m., an interview was icensed Practical Nurse) that the wrong antibiotic if to Resident #1 on it that she worked the 7 N #3 stated that she had not so room to give Resident and on the IV pole. LPN #3 that IV bag had a different in the different in the realized that		760		
	antibiotic. LPN #3 state than Zosyn was hangir #3 stated that she confithat he had been admit that had been hanging that she had made the received Cefazolin rath stated that Resident #1 allergic to Keflex, which antibiotic family as Cefshe called the on call p	administered the wrong and that Cefazolin rather ag from the IV pole. LPN firmed with the resident ensistered the antibiotic bag on the pole. LPN #3 stated resident aware that he had are than Zosyn. LPN #3 had told her that he was an was in the same family azolin. LPN #3 stated that hysician and DON amediately. LPN #3 stated				

CENTERS FOR MEDICARE & MEDICAID SERVICES

OL. TIL	TO TOTAL WEDIOARE &	INCORD SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495309	B. WING			C 08/19/2021		
	PROVIDER OR SUPPLIER  HEALTH NORFOLK			827 N	ET ADDRESS, CITY, STATE, ZIP CODE ORVIEW AVENUE FOLK, VA 23509	1 00/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 760	Continued From page	82	F	760				
	that the physician gave current antibiotic sche Resident #1 for any as stated that she assess continued monitoring remainder of her shift. Resident #1 did not hat her on the night shift. was who administered stated it was the nurse shift, but that she coul she was an agency nurse revealed he had allerg On 8/18/21 at 11:27 a. attempted with the nurse current with the nurse shift, but that she coul she was an agency nurse was an agency nurse could be shad allerged.	e an order to continue to his dule and to monitor dverse reactions. LPN #3 sed the resident and then every hour for the LPN #3 stated that ave any type of reactions for When asked who the nurse I the antibiotic, LPN #3 a who worked 7 a to 7 p dn't remember her name as irse.  dent #1's clinical record ies to Keflex (antibiotic) (4).		700				
	On 8/18/21 at 12:25 p. attempted with the nur for Resident #1. She conterview.  On 8/18/21 at 12:30 p. conducted with OSM (of the Pharmacist. When the wrong intravenous significant reactions, Of error with antibiotics condepending on allergies	se had ordered Benedrayl could not be reached for an m., an interview was Other Staff Member) #7, asked if giving one dose of antibiotic could lead to SM #7 stated that any ould be significant or any comorbidities the						
	to Keflex if that automa have a reaction to Cefa even though Keflex and the same antibiotic fam	azolin, OSM #7 stated that d Cefazolin were part of						

CENTERS FOR MEDICARE & MEDICAID SERVICES

1		MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING _			C
	ROVIDER OR SUPPLIER HEALTH NORFOLK			827 NO	ADDRESS, CITY, STATE, ZIP CODE RVIEW AVENUE DLK, VA 23509	08/19/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	4	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 760	OSM #7 stated that a first generation Cepha generation.  On 8/19/21 at 2:49 p.r Member (ASM) #1, the the DON (Director of Negional Director of Cepha generation).  #5, the corporate nurse above concerns. When in services were provided in services were provided as the agency nurse in facility to work another services were done for regarding preventing in the services.	m., Administrative Staff e Administrator, ASM #2, Nursing), ASM #3, the elinical Services, and ASM e were made aware of the n asked if any education or ded regarding the above M #2 stated that she did not ever came back to the	F 76	i0		
	Facility policy titled, "M in part, the following: "I to provide protections in rights of each resident receive care and service environment free of signerorsSignificant med which causes the residigeopardizes his/her head medication errors and administration, nurses information:  a. Right medication, do administration;  b. Right resident and right	ces safely in an prificant medication dication error means one lent discomfort or alth and safety To prevent ensure safe medication should verify the following ese, route, and time of ght documentation."  was presented prior to exit.  as Tazocin®				

PRINTED: 08/31/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495309 B. WING 08/19/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE PELICAN HEALTH NORFOLK NORFOLK, VA 23509 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 760 Continued From page 84 F 760 administered antibiotic. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC25 04059/. (2) Cefazolin is a beta-lactam antibiotic and first-generation cephalosporin with bactericidal activity. This information was obtained from the National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/cefa (3) Benedrayl temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: runny nose itchy, watery eyes, sneezing, itching of the nose or throat and temporarily relieves these symptoms due to the common cold: runny nose and sneezing. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=af5053d8-ba02-4cdf-877f-8c1e368dafe0 (4) Keflex Capsules (Cephalexin, USP) is a semisynthetic cephalosporin antibiotic intended for oral administration. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru gXsl.cfm?setid=68fba58a-7748-4581-8432-f5286 c46d90a. COMPLAINT DEFICIENCY