STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Infection Control survey was conducted 05/18/2021 though 05/20/2021. The facility was in compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid COVID-19 Infection Control survey was conducted on 5/18/21 and continued offsite through 5/20/21. Two complaints were investigated: VA00050073 both allegations (#1 and #2) were substantiated with deficiencies and VA00051754 was substantianted with deficiences. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 90 certified bed facility was 69 at the time of survey. Since the start of the pandemic a total of 21 residents had tested positive for COVID-19 with a total of 18 resident recoveries. Since the start of the pandemic a total of 20 staff had tested positive for COVID-19 with a total of 19 staff recoveries. There had been 2 resident deaths related to COVID-19. The survey sample consisted of 5 current residents (Resident #1 through Resident #5) and two closed record reviews (Resident #6 through #7).	F 000		

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

Electronically Signed | 06/18/2021

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		6/28/21

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F 578	Continued From page 2 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to allow 1 of 7 residents (Resident #6) an opportunity to formulate an Advance Directive. The findings included: Resident #6 was admitted to the facility on 5/21/20 with diagnoses of hypertension, GERD, diabetes, dementia, psychotic disorder, asthma and arthritis. Resident #6 was not provided an opportunity to formulate an Advance Directive. An Initial Minimum Data Set dated 5/25/20 assessed this resident as having been coded as a (1) on the Basic Interview for Mental Status (BIMS). This resident was assessed (3/2) in the area of bed mobility, (3/3) in the area of transfer, (1/1) in the area of dressing. In the area of Speech this resident was coded as (usually understood) as well as (usually understands others). A Social Service Note dated 5/22/20 at 2:45 PM indicated: "Resident was admitted to the facility to room 115 P on 5/21/20 under skill level of care. Social worker will provide supportive therapy weekly. Social worker, Director of nursing and Assistant director of nursing have a conference call with resident's wife to discuss resident's code status and the concern of resident not being safe to eat. Due to his medical history from the hospital read, he failed the swallow study x 3 and he is a silent aspirator. Which he (sic) puts resident at a high risk. This was explained to	F 578	F578 1. Resident #6 was discharged on 6/9/2020 and did not return to the facility. 2. A complete audit of all current residents advance directives has been completed on 6/10/21 to ensure that all residents have been given an opportunity to formulate an advance directive. During the audit, no instances have been identified where the facility failed to follow the Advance Directive policy. 3. The Interdisciplinary team will be reeducated on advance directive policy 06/25/2021-06/28/2021. The Social services director will offer all new admission the opportunity to develop an Advance Directive with confirmation recorded quarterly. Administrator or designee will audit all admissions monthly x 3 months to ensure compliance. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.	

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F 578	Continued From page 3 resident's wife in great detail. At that point it was explain to resident's wife she would have to sign a Dietary Waiver and a DNR form, She was aware that telephone call was placed to physician and we are awaiting for a return to discuss this matter further. In (sic) this writer did receive a telephone call from physician and he informed writer that he had spoken to resident's wife the re: matter of resident need to be a DNR Status Code and she did agree. Physician also informed writer to have resident's wife to sign a Dietary Waiver. Social worker telephoned resident's wife and informed her of the MD recommendation. Resident's wife informed writer as well that she have spoken to physician as well and she gave a verbal consent for a DNR code status and she gave verbal consent for a Dietary Waiver. Social Worker informed her that she will mail the form with a self-address envelope. Social worker will continue to f/u on this matter." During an interview on 05/20/21 at 12:36 PM with the Director of Nursing (DON) she was asked if Resident #6's Representative had been offered the opportunity to formulate an Advance Directive. The DON stated, not to her knowledge. She stated, Resident #6's wife had spoken with the physician who recommended Resident #6 be a DNR. On 05/20/21, the facility administrator was asked for a copy of the facility's Advance Directive policy during the survey. No policy was provided prior to the exit of survey.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		6/28/21

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F 607	Continued From page 4 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the facility's abuse policy and ensure a criminal background check was completed upon hire for one of two employee records reviewed. The findings included: On 5/19/21 at approximately 3:00 p.m., two employee files were requested from OSM (Other Staff Member) #6, Human Resources during a complaint investigation. One out of two employee files reviewed revealed that there was no criminal background check completed at the time of hire in 2005 or thereafter. On 5/19/21 at 4:20 p.m., an interview was conducted with OSM (Other Staff Member) #6, human resources. OSM #6 stated that she thought that maybe nursing facilities were not requiring criminal background checks back in 2005. OSM #6 stated that she had only worked at	F 607	F607 1. A criminal background check was completed for OSM #6 on 6/2/2021. No findings were noted. 2. A complete audit of all active employees criminal background check records has been completed on 6/3/21 to determine potential risk to residents. There were no findings noted. 3. The BOM was educated on 6/15/2021 to assure all elements of the facility s Abuse Prevention policy are followed to include criminal background checks for all staff. The Administrator or designee will audit all new hires weekly x 8 weeks to ensure ongoing compliance. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations. 6/28/21	

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F 607	Continued From page 5 the facility for 4 years. When asked if she ever does audits to ensure all employee files have a criminal record check, OSM #6 stated that she has never been told to do an audit. On 5/20/21 at 10:54 a.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants."	F 607		
F 609 SS=D	COMPLAINT DEFICIENCY Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		6/30/21

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F 609	Continued From page 6 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that facility staff failed to report an allegation of sexual abuse that was reported to the facility administrator on 5/5/21 from APS (Adult Protective Services) to the appropriate state agency within the required timeframe for one of seven sampled, residents; Resident #7. The findings included: Resident #7 was admitted to the facility on 3/29/21 with diagnoses that included but were not limited to chronic urinary retention, high blood pressure, chronic kidney disease stage three, cognitive impairment, peripheral neuropathy, arthritis and osteoarthritis. Resident #7's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 4/6/21. Resident #7 was coded as being severely cognitive intact	F 609	F609 1. Resident #7 was discharged home from the facility on 5/3/21 and did not return. 2. All residents are at risk if the allegation of abuse is not reported timely. 3.Staff will continue to receive ongoing education regarding abuse prevention and reporting requirements. Additional education will be provided for the interdisciplinary team on proper reporting of alleged violations and required timeframe. Abaqis abuse interviews will be conducted by 6/30/21 for continued abuse prevention monitoring. Social services director will continue to interview 5 residents per month for the next 8 weeks for abuse prevention monitoring. All reports of alleged violations of abuse, neglect, exploitation, or mistreatment, will be reviewed for compliance by Regional Director of Operations.	

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F 609	Continued From page 7 in the ability to make daily decisions. Review of a facility FRI (Facility Reported Incident) dated 5/6/21 documented the following: "Initial/FRI Report forwarded to (Name of State Surveying Agency): 5/6/21...Resident Age: 90...Diag (Diagnoses): Unspecified Dementia with behavioral disturbance, major depressive disorder, hearing loss, personal history of COVID-19, retention of urine, Chronic Kidney disease, Stage 3. Resident sent to hospital midday Mon (Monday) 5/3/21 for urethral bleeding. Facility received call from APS 5/5/21 stating that resident, now in hospital, just recalled she was raped by staff member named (David) sometime between Sunday (5/2/21) and Monday (5/3/21) pre-admission into the hospital. Facility immediately investigated: Facility does not employ a staff member (Name) nor did any male giver staff resident's unit Sunday evening or Monday morning. Resident has documented history of hallucinations including "bugs in her vagina" and "men standing in her room laughing at her." Resident was also recently observed crying while saying "I wish someone would love me." Resident has also seen by geropsyh. PA (Physician Assistant) recently ordered antipsychotic to alleviate episodes but POA/daughter prohibited administration, stated, "I'd rather her have hallucinations than allow (Drug)." Within the past month resident removed her full (sic) catheter at least twice which the PA suggested may have caused trauma to her internally. This may have initiated her bleeding and why PA sent resident to the hospital. Hospital physicians were not aware of resident's history and ordered a rape kit, which was a concern to APS (Name of APS Worker) as it is an invasive procedure, especially for a 90 y/o (year old)	F 609	4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.	

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F 609	Continued From page 8	F 609		

woman. Administrator contacted POA (Power of Attorney), explained situation. POA stated she did not know anything about a rape kit, she denied any knowledge of antipsych treatment and stated that she would be following up with APS and hospital. Documentation was emailed to APS 5/5 and faxed 5/6. In follow up call with APS by facility Social Service Director on 5/6. APS stated that they determined incident "Unsubstantiated" partly because resident's behavior was noted in hospital. Administrator also has a call out to resident's hospitalist for follow up....Conclusion: Unsubstantiated."

Review of the above FRI revealed that APS had contacted the facility administrator on 5/5/21 with an allegation of rape but it was not reported to the state surveying agency until 5/6/21. The facility administrator could not present a fax confirmation of the exact time stamp of when the FRI was submitted to the state surveying agency. The facility administrator was able to send a screen shot of the fax history from the fax machine. Review of the screen shot revealed that the FRI was not submitted to the state surveying agency until 5/6/21 at 5:09 p.m.

On 5/20/21 at 10:30 a.m., an interview was conducted with ASM (Administrative Staff Member) #1, the facility administrator. When asked who the abuse coordinator was, ASM #1 stated he was. When asked when he would report an allegation of abuse to the appropriate state agencies, ASM #1 stated "If harm, maybe two hours." ASM #1 stated that he was able to send the initial and Final FRI together because as soon as APS had called, he started an investigation and through "Conversation and research" it was already unsubstantiated. ASM #1

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F 609	Continued From page 9 stated that it was his understanding that Resident #7's bleeding was urethral in nature and that the bleeding had stopped. ASM #1 stated, "What we did was appropriate." On 5/20/21 at 10:54 a.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "Reporting/Response...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: a. 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..."	F 609		
F 610 SS=D	Complaint Deficiency Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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. §483.12(c)(4) Report the results of all	F 610		6/28/21

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F 610	Continued From page 10 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 staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that facility staff failed to thoroughly investigate an allegation of sexual abuse that was reported to the facility Administrator on 5/5/21 from APS (Adult Protective Service) for one of 7 sampled residents, Residents #7. The findings included: Resident #7 was admitted to the facility on 3/29/21 with diagnoses that included but were not limited to chronic urinary retention, high blood pressure, chronic kidney disease stage three, cognitive impairment, peripheral neuropathy, arthritis and osteoarthritis. Resident #7's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 4/6/21. Resident #7 was coded as being severely cognitive intact in the ability to make daily decisions. Review of Resident #7's clinical record revealed that she was admitted to the facility with a Foley catheter. The following order was documented: "16 FR (French) Foley W/10 cc balloon." Review of Resident #7's care plan dated 3/29/21 documented the following: "The resident has Indwelling Catheter for urinary retention."	F 610	F610 1. Resident #7 was discharged to acute care 5/3/21 and did not return. Interviews for staff and residents will be conducted by 6/30/21. 2. All residents are at risk if a thorough investigation is not conducted. 3. Interdisciplinary team was reeducated on proper abuse allegation procedure and components of a complete investigation to include staff and resident interviews. 20% of residents will be interviewed quarterly to assure continued abuse prevention monitoring. Any abuse investigation will be reviewed by Regional Director of Operations for thoroughness and completeness. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations. 6/28/2021	

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Review of Resident #7's April TAR (treatment administration record) revealed that on 4/8/21, Resident #7 was started on Macrobid (Antibiotic) 100 mg BID (two times a day) for 7 days for a UTI (Urinary Tract Infection). Review of her culture and sensitivity dated 4/8/21 documented the following: "Urine Greater than 100,000 CFU/ML mixed culture: (3) or more organisms isolated suggest repeat culture to rule out contamination."

Review of Resident #7's clinical record revealed that Resident #7 had pulled out her Foley catheter on 4/19/21. The following was documented by the nurse: "received resident lying in bed awake...Day 1/3 s/p (status post) reinsertion of Foley. No c/o (complaints) pain. Resident pulled Foley out with bulb intact. Replaced Foley using sterile technique. NP (Nurse Practitioner) and RP (Responsible Party) notified..."

Further review of Resident #7's clinical record revealed that she pulled her Foley catheter out for the second time on 4/20/21. The following was documented: "...resident pulled out Foley. stated that "a girl from last night pulled the Foley out." no c/o (complaints) of pain...no n/o for new Foley...n/o (new order) Seroquel (antipsychotic) 12.5 mg (milligrams) BID (two times daily) x 10 days, follow up with psych and urology. NP and RP at 12:27...Resident states that she sees bugs in her bed and they crawl all over her. Resident states that there are people in the room who laugh at her...Will continue to monitor."

A note from the NP (Nurse Practitioner) dated 4/20/21 documented the following: "Chief Complaint: Hallucinations...Nursing staff reports

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patient with increased anxiety, experiencing visual hallucinations, stated man from the doorway laughing at her. Staff stated there was not a man physically standing there at the time of the statement. Patient trying to point out "bugs" to nursing staff that are not physically present. Patient also stated Foley Catheter was putting bugs inside her genital area. Patient forcefully removed Foley catheter. Nursing reports no active bleeding. Patient completed 7 day course of Macrobid for UTI on 4/15. Patient family reports patient with visual hallucinations prior to hospitalization and rehab admissions...Repeat U/A (urinalysis) C and S (Culture and Sensitivity)...Start Seroquel (antipsychotic) 12.5 mg BID x 10 days, follow up with psych. (psychological services)."

Review of a nursing note dated 4/21/21 documented the following: "Attempted to obtain UA, C +S via straight cath. resident very resistant unable to obtain. Resident noted to be voiding while attempting to cath. Meatus noted to have edema and small amount of bleeding. Nursing staff will continue to assist."

Further review of Resident #7's clinical record revealed several refusals from Resident #7 to be straight cathed for a urine specimen.

Review of a note dated 4/23/21 from the psych physician documented in part, the following: "...psych evaluation for depression, anxiety, dementia with hallucinations and behaviors, BPSD (Bipolar disorder), and currently on Seroquel...Patient is actively responding to internal stimuli, verbalizing she is seeing bugs on the walls. Physical therapy notes patient noted bugs crawling up her legs and in her shoe during

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therapy. Staff reports patients has episodes of screaming and pain associated with auditory and visual hallucinations, but no behaviors noted. Provider is aware that POA (Power of Attorney) has verbalized that antidepressants and antipsychotics are not agreeable to patient care plan. Continue to monitor and support. Symptoms present and monitored. Seroquel discontinued at this time. No labs ordered at this time..."

A note dated 4/30/21 by the unit manager documented in part, the following: "Spoke with RP (Responsible Party) r/t (related to) concerns about resident Foley removal. Advised RP after resident pulled Foley out NP (Nurse Practitioner) gave orders to straight cath if no void in 8 hours D/T (due to) vagina area being red and swollen and resident's behaviors of feeling like the Foley is putting bugs in her. Also reminded RP of resident urology appointment on 5/21 and resident output is being monitored q (every) shift..."

Further review of Resident #7's clinical record revealed that psych had seen Resident #7 for the second time on 4/30/21. The following was documented in part: "decreased episodes of labile mood and overall improved with no recent hallucinations..."

On 5/3/21 evening shift, it was observed by a CNA (Certified Nursing Assistant), that Resident #7 was having heavy bleeding. The following was documented in a nursing note: "Assumed care of Resident sitting in w/c (wheelchair) in TV room. A & O x 2 (Alert and Oriented x 2) able to communicate needs. During med (medication) pass resident noted wheeling to room. When I ask if I could help with anything, resident stated,

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"I'm going to my room for a while and I have to use the bathroom. CNA assisted resident to the bathroom. When CNA pulled residents pull-up down a golf ball size blood clot, Resident note with blood dripping down legs. Blood noted in commode, unable to see clearly to bottom of commode due to blood in urine...Resident denies pain to and (abdomen), stated "I feel fine, I ate a good breakfast." Nurse practitioner called, new order to hold blood thinner and sent to ER (Emergency Room). POA called and made aware of order, stated ok to send resident out 911. Resident admitted to (Name of Hospital) related to Hematuria (Blood in urine).

Review of a facility FRI (Facility Reported Incident) dated 5/6/21 documented the following: "Initial/FRI Report forwarded to (State Surveying Agency): 5/6/21...Resident Age: 90...Diag (Diagnoses): Unspecified Dementia with behavioral disturbance, major depressive disorder, hearing loss, personal history of COVID-19, retention of urine, Chronic Kidney disease, Stage 3. Resident sent to hospital midday Mon (Monday) 5/3/21 for urethral bleeding. Facility received call from APS 5/5/21 stating that resident, now in hospital, just recalled she was raped by staff member named (David) sometime between Sunday (5/2/21) and Monday (5/3/21) pre-admission into the hospital. Facility immediately investigated: Facility does not employ a staff member (Name) nor did any male giver staff resident's unit Sunday evening or Monday morning. Resident has documented history of hallucinations including "bugs in her vagina" and "men standing in her room laughing at her." Resident was also recently observed crying while saying "I wish someone would love me." Resident has also seen by geropsych. PA

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(Physician Assistant) recently ordered antipsychotics to alleviate episodes but POA/daughter prohibited administration, stated, "I'd rather her have hallucinations than allow (Drug)." Within the past month resident removed her full (sic) catheter at least twice which the PA suggested may have caused trauma to her internally. This may have initiated her bleeding and why PA sent resident to the hospital. Hospital physicians were not aware of resident's history and ordered a rape kit, which was a concern to APS (Name of APS Worker) as it is an invasive procedure, especially for a 90 y/o (year old) woman. Administrator contacted POA (Power of Attorney), explained situation. POA stated she did not know anything about a rape kit, she denied any knowledge of antipsych treatment and stated that she would be following up with APS and hospital. Documentation was emailed to APS 5/5 and faxed 5/6. In follow up call with APS by facility Social Service Director on 5/6. APS stated that they determined incident "Unsubstantiated" partly because resident's behavior was noted in hospital. Administrator also has a call out to resident's behavior was noted in the hospital. Administrator also has a call out to resident's hospitalist for follow up....Conclusion: Unsubstantiated."

On 5/18/21 during an entrance conference at 10:30 a.m., with ASM (Administrative Staff Member) #1, the Administrator; a full investigation related to the above FRI (Facility Reported Incident) was requested.

The facility Administrator could only provide parts of Resident #7's clinical record that reflected her previous behaviors/hallucinations, Foley catheter use and the resident's two successful attempts at

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removing her Foley with the bulb still intact. There was no evidence that facility staff were interviewed regarding the above allegation of sexual abuse. There was no evidence that facility residents were interviewed regarding abuse in the facility.

On 5/19/21 at 10:00 a.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that Resident #7 was sent to the hospital for bleeding in her urine and that the doctor had wanted her to go. ASM #1 stated that he received a call from APS (Adult Protective Services) on 5/5/21 while the resident was at the hospital stating that the resident had made an allegation of rape from a staff member named (Name) at the nursing facility. ASM #1 stated that he investigated and immediately "became aware of her (Resident #7's) background." ASM #1 stated, "The Police had suggested to do a rape kit and that sent a red flag up to APS because the resident is 90 years old with a history of delusions, hallucinations." ASM #1 stated that APS and the police were not aware of the resident having a previous catheter that she kept pulling out. ASM #1 stated that he talked to APS and that all the "Conversations were done." ASM #1 stated that he put a call out to Resident #7's hospitalist and that the hospitalist had returned his call the following day (5/6/21) and stated that he was not aware of Resident #7 pulling out her catheter. ASM #1 stated that the bleeding was urethral not vaginal per his understanding. ASM #1 stated that due to the resident's previous history, he unsubstantiated the allegation of sexual abuse. When asked if he had interviewed all staff who had worked with Resident #7 during the days in question (days allegation occurred) and after the days in question; ASM #1 stated, "It

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was news to everyone on the floor." ASM #1 then stated, "We just don't have a nurse with that name or a CNA (certified nursing assistant) with that name. ASM #1 stated that a male nurse did not work with Resident #7 on 5/1/21 or Sunday (5/2/21) and Monday (5/3/21) before she had gone out to the hospital. When asked where his staff witness statements were located if he had talked to floor staff and learned it was "All news" to them; ASM #1 stated, "I'll ask about nursing or social services with staff interviews. I can't talk specifics. I wasn't involved in the specifics." ASM #1 stated that this writer could talk to the Social Worker OSM (Other Staff Member) #3 but that she would be coming in late that day.

On 5/19/21 at 10:30 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the nurse who worked with Resident #7 on both occasions (4/19/21 and 4/20/21) when Resident #7 had pulled out her Foley catheter. LPN #3 stated that Resident #7 used a catheter for urinary retention and that the Foley was reinserted after the first time she had pulled it out. LPN #3 stated that the bulb was fully intact/inflated both time Resident #7 pulled it out. LPN #3 stated that the physician did not want to reinsert the Foley after the second time it was pulled out in fear it would cause urethral trauma. LPN #3 stated that during inspection to Resident #7 peri area; she did not notice any visible signs of trauma such as swelling and bleeding after the first time the Foley was pulled out. LPN #3 stated that there was some swelling and trace bleeding after the second removal but that the resident was not acting out in pain. LPN #3 stated that Resident #7 had admitted to pulling out the Foley the first time but did not give an answer the second time when the Foley was found lying on

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her bed right next to her. LPN #3 stated that the resident would then start crying; but not due to pain but because there were people in her room laughing at her. LPN #3 then stated Resident #7 had changed her story about the first time the Foley was pulled out and stated that a male had pulled it out and was laughing at her in her room. LPN #3 stated that there were no visible people in her room at that time. LPN #3 stated that she discussed this with Resident #7's daughter and that the daughter had stated that Resident #7 would hallucinate all the time prior to admission, and that this was not concerning to the daughter. LPN #3 stated that on both occasions the Foley catheter was removed, there was no evidence of any males going into her room. When asked if LPN #3 had worked with Resident #7 on 5/2/21 or 5/3/21; LPN #3 stated that she didn't think she had. When asked if she knew anything regarding a recent allegation made of sexual abuse regarding Resident #7, LPN #3 stated that she wasn't aware of any allegations made. When asked if administration had interviewed LPN #3 regarding Resident #7 and any allegations made of sexual abuse, LPN #3 stated that no one asked her for a witness statement.

On 5/19/21 at 2 p.m., an interview was conducted with the nurse (LPN #2) who was assigned to Resident #7 on 5/3/21; the day Resident #7 started heavily bleeding. LPN #2 stated that she worked 7-3 shift and earlier that shift, there was no evidence of bleeding. LPN #2 stated that she started her afternoon medication pass and noticed the resident propelling to her room, LPN #2 stated that she asked Resident #7 if she needed anything and that Resident #7 stated, "I just have to pee." LPN #2 asked the CNA on duty to assist Resident #7 with the bathroom. LPN #2

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stated that is when the CNA yelled for the nurse to come look at Resident #7. LPN #2 stated that the CNA noticed a blood clot and saw blood in the toilet. LPN #2 stated that she assessed the resident and observed that it appeared to be coming from the vagina. LPN #2 stated that she held the resident's blood thinner and sent the resident out to the hospital per NP orders. LPN #2 stated that she recommended the resident stay in bed until EMS (Emergency Medical Services) arrived. LPN #2 stated that the resident stated that she had "felt fine." LPN #2 stated that upon assessment, Resident #7 did not complain of abdominal pain or expressed any nonverbal signs of pain. When asked if Resident #7 had any behaviors of digging at her vaginal area or complaints of burning, LPN #2 stated, "Not to my knowledge." LPN #2 stated that Resident #7 did not appear to be swollen. When asked if Resident #7 had made any allegation of a male staff member "raping" her on any dates from 5/1/21 through 5/3/21; LPN #2 stated, "She never mentioned any allegation of a staff member raping her. I heard some allegation going on. I didn't hear anything other than that." When asked if administration had interviewed her regarding any allegations made of sexual abuse by Resident #7; LPN #2 stated that she was questioned regarding her assessment on Resident #7 at the time of bleeding and when the bleeding was discovered. LPN #2 stated that she referred them to her note. When asked the process if a resident makes her aware of an allegation of abuse from a staff member; LPN #2 stated that if she was made aware of an allegation of any abuse, she would immediately remove the accused staff member, notify the DON, ADON, and write down a statement for them. LPN #2 stated that the "ADON (Assistant

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Director of Nursing) and DON (Director of Nursing) would take it from there."

On 5/19/21 at 11:55 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #1, the CNA who found Resident #7's blood clot. When asked if she had worked with Resident #1 frequently, CNA #1 stated that she did. When asked if she could describe the events of 5/3/21, CNA #1 stated that she took the resident to the bathroom sometime after lunch and saw blood and clots in the toilet. CNA #1 stated she thought to herself, "This isn't right, she shouldn't be bleeding." CNA #1 stated that when the resident got up, more blood fell into the toilet. CNA #1 stated that she had worked with the resident 7-3 shift and that there was no signs of bleeding earlier that day. CNA #1 stated that Resident #7's bleeding was from her vaginal area. When asked if Resident #7 had made her aware of any allegations of sexual abuse from a male staff member in the days leading up to her bleeding; CNA #1 stated, "No she didn't." When asked if anyone such as administration had obtained a witness statement from her regarding any sexual allegation made by Resident #7; CNA #1 stated that she wasn't aware of any allegations made until this conversation with this writer. When asked the process if a resident were to make an allegation of abuse; CNA #1 stated that she would report the allegation immediately to the supervisor.

On 5/19/21 at 12:21 p.m., an interview was conducted with OSM #3, the facility social worker. When asked when she was made aware of an allegation of rape made by Resident #7; OSM #3 stated that she found out that morning on 5/6/21 during a morning meeting. OSM #3 stated that

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she was aware that APS had called the administrator. OSM #3 stated that later that day she had reached out to the APS worker herself. OSM #3 stated that she was made aware that the police were conducting a rape kit test and that it was alleged that a nurse name "David" had raped her. OSM #3 stated that she told the APS worker that they did not have a nurse by that name. OSM #3 stated that she knew Resident #7 was "Very demented, hallucinates; seeing bugs in her bed." OSM #3 stated that the day before she was hospitalized Resident #7 was "sitting in the front lobby not knowing what she was doing." OSM #3 stated that Resident #7 was seeing psych services due to her hallucinations. When asked if staff were interviewed to obtain witness statements regarding Resident #7's allegation of abuse, OSM #3 stated, "I don't know." OSM #3 stated that she did meet with residents who resided on the same hallway as Resident #7 the day after she was made aware (5/7/21). OSM #3 stated that she interviewed all the cognitively intact residents as well as male residents regarding abuse. OSM #3 stated that kept a roster of residents and documented a "No" beside each resident name. OSM #3 stated that none of residents questioned verbalized any abuse by other residents or staff members. OSM #3 stated that she did not actually document her entire conversation with each resident. OSM #3 stated that she would have the administrator send all her documentation to this writer.

On 5/19/21 at 2:44 p.m., ASM (Administrative Staff Member) #1, presented a resident roster that documented, "No" beside some of the resident's name on the 200 unit (Rose Garden). At the bottom of the roster the following was documented: "Social Worker Interviewed on

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5/7/21 to inquire if anyone had physical or verbal abuse or touch in a wrong manner?" This statement was signed by the facility social worker on 5/7/21. The social worker failed to document her entire conversation that she had with each resident regarding abuse in the facility. Further review of the roster revealed that residents were not interviewed until after the Final FRI was submitted and determined to be "Unsubstantiated."

On 5/19/21 at 1:08 p.m., an interview was conducted with the ASM #4, the nurse practitioner. When asked if Resident #7's bleeding on 5/3/21 was urethral or vaginal, ASM #4 stated that she was notified of the bleeding found in Resident #7's urine but that she had ordered the resident to be sent out to the ER for further evaluation. ASM #4 stated that Resident #7 had been without a Foley for about a week prior to the heavy bleeding found on 5/3 and that there had been no significant bleeding at that time Resident #7 pulled out her Foley catheter. ASM #4 stated that she did not have a definitive answer. ASM #4 stated that if the bleeding was related to her Foley being pulled out, she would expect that the resident would have had some sort of continuous bleeding. When asked if Resident #7 had made any abuse allegations regarding rape to her; ASM #4 stated that she had did a telehealth visit with Resident #7 the morning of 5/3/21 and that the resident had not mentioned any allegations related to rape. ASM #4 stated that by the time she arrived to the facility on 5/3/21, Resident #7 was already being sent out and therefore she could not conduct a physical assessment of the bleeding.

On 5/19/21 at 2:08 p.m., an interview was

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conducted with OSM #4, the APS worker. OSM #4 stated that the hospital had called APS on 5/4/21 but that she did not receive her case until 5/5/21. OSM #4 stated that on Wednesday the 5th; she had called the hospital to ensure Resident #7 was still there. OSM #4 stated that a police officer had come out the night prior, but that the resident would not talk or say anything. On the 5th, OSM #4 stated that she arranged a FaceTime meeting with the Resident and the resident had stated that the OBGYN had looked at her and stated there was extensive trauma to her vaginal area. OSM #4 stated that she got the detective back in there and when Resident #7 was questioned about what had happened, OSM #4 stated, "At first the resident wouldn't say anything; and then out came all these details about how a man came up from behind her and forced himself inside her." ASM #4 stated that, "Details flooded out like a novel she had read somewhere." OSM #4 then stated that even though these details were presented, she could not identify or really recall the alleged staff member. OSM #4 stated she kept saying the name "David" but could not describe him. OSM #4 stated that she then called over to the facility who had no idea of an allegation of sexual abuse. OSM #4 stated that the resident had a history of pulling out her Foley catheter which may have been the cause of her extensive trauma to her vaginal area. OSM #4 stated that the facility had made her aware that the resident was recommended to be on Seroquel but that the guardian did not want her to be on any type of antidepressant. OSM #4 stated that she was then made aware of Resident #7's hallucinations of "bugs coming from her vagina" and a male gentleman being present in her room when no one was visibly present by staff. OSM #4 stated

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CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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that the facility had made her aware that there was no male nurse or CNA by the name of "David" working at the facility. OSM #4 stated that the Resident wanted to proceed with the rape kit and a detective/SANE (Sexual Assault Nurse Examiner) had performed an examination Wednesday night. OSM #4 stated that the SANE nurse did not see any evidence of sexual assault. OSM #4 stated that the rape kit full results were not back yet, but there was no evidence of any physical trauma. OSM #4 stated that she had to unsubstantiate the allegation because there was "no suspect." OSM #4 then stated that the resident had also claimed she was raped through the anus rather than the vaginal area. OSM #4 confirmed that the SANE nurse had examined that area too.

On 5/19/21 at 4:32 p.m., Resident #7's hospital records were reviewed. The following was documented on the admission H and P (History and Physical) dated 5/3/21: "...90 year old elderly demented female who is currently staying at (name of facility) who presents with bleeding in her diapers... I did speak to the gynecologist who did a limited exam...she states she was able to pull out some blood clots from the patient's vagina but she also states she is uncertain where it is coming from...She stated even on anticoagulation patient should not have the significant bleeding from her vagina quantity is more suggestive of uterine or endometrial cancer...daughter is aware will be nonaggressive at this time unless the patient continues to have active bleeding...Acute Blood Loss anemia (no bleeding since being admitted)...Seroquel 25 mg qhs appears to be helping her...daughter appears unaccepting that her mother has dementia and behavioral disturbances that go with her

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dementia."

There was no evidence in the hospital records that Resident #7's bleeding was from a traumatic injury.

Review of the As-worked schedule revealed that no male nurses or CNAs had worked with Resident #7 on 5/1/21 through 5/3/21.

On 5/20/21 at 9:15 a.m., further interview was conducted with OSM #4, APS. When asked if she had alerted the facility administrator in the manner in which Resident #7 had alleged she was raped, OSM #4 stated that she didn't think she did.

On 5/20/21 at 9:30 a.m., an interview was conducted with OSM #5, the police detective. OSM #5 stated that samples were obtained from both Resident #7's vaginal and rectal area. OSM #5 stated that there was no report back yet from the SANE nurse, but that the SANE nurse as only seen residue from the resident's brief so far. OSM #5 stated that no physical trauma was found, but that just because trauma was not identified, does not mean that the allegation did not happen. OSM #5 stated that a SANE report is not going to say "yes this happened or no it didn't." OSM #5 stated that their findings will result from the "totality of the investigation." OSM #5 stated that the hospital could not determine why the resident was bleeding. OSM #5 also stated she really didn't have much information to go and that the suspect identified was not someone who existed in the facility. OSM #5 also stated that Resident #7 kept changing her story as well.

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On 5/20/21 at 10:30 a.m., further interview was conducted with ASM #1, the facility administrator. When asked who the abuse coordinator was, ASM #1 stated he was. When asked when he would report an allegation of abuse to the appropriate state agencies, ASM #1 stated "If harm, maybe two hours." ASM #1 stated that he was able to send the initial and Final FRI together because as soon as APS had called, he started an investigation and through "Conversation and research" it was already unsubstantiated. ASM #1 stated that it was his understanding that Resident #7's bleeding was urethral in nature and that the bleeding had stopped. ASM #1 stated, "What we did was appropriate." When asked if APS had gone over the manner in which Resident #7 was alleging to be raped, ASM #1 stated he thought it was presented to him that she was raped vaginally. This writer informed ASM #1 that per conservation with OSM #4, Resident #7 was alleging rape to her rectal area. This writer also informed ASM #1 that Resident #7's bleeding was not "urethral in nature" but was vaginal bleeding per hospital records.

On 5/20/21 at 10:54 a.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "...An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation...Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the

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F 610	Continued From page 27 allegations...providing complete and thorough documentation of the investigation."	F 610		
F 622 SS=D	COMPLAINT DEFICIENCY Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622		6/21/21

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F 622	Continued From page 28 (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F 622		

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F 622	Continued From page 29 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to ensure the comprehensive care plan goals for 1 of 7 residents (Resident #6) in the survey sample was sent upon transfer to the hospital on June 9, 2020. The findings included: Resident #6 was admitted to the facility on 5/21/20 with diagnoses of hypertension, GERD, diabetes, dementia, psychotic disorder, asthma and arthritis. Resident #6 medical records did not include documentation of a Plan of Care to meet the needs of this individual and appropriate information is communicated to the receiving health care institution during a transfer to the hospital. An Initial Minimum Data Set dated 5/25/20 assessed this resident as having been coded as a (01) on the Basic Interview for Mental Status (BIMS). This resident was assessed (3/2) in the	F 622	F622 1. Resident #6 was discharged on 6/9/2020 and did not return to the facility. 2. All residents are at risk if care plan information is not communicated upon transfer to an acute care setting. 3. Education will be provided for all licensed direct care staff regarding transfer and discharge policy and necessary information for the receiving provider which includes the resident□s care plan goals. Director of Nursing or designee will audit 100% of all discharged resident charts X 8 weeks to ensure appropriate transfer and discharge documentation has been given. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations. 6/21/21	

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F 622	Continued From page 30 area of bed mobility, (3/3) in the area of transfer, (1/1) in the area of dressing. In the area of Speech this resident was coded as (usually understood) as well as (usually understands others). An Initial Care Plan dated 5/21/20 indicated: Resident #6 was at risk for choking. A Nursing Note dated 06/10/20 at 8:26 AM on June 9, 2020 approximately 1:30 PM it was brought to my attention that resident who is s/p fall day 1, no acute injuries, but has a slight change in mentation, is swatting at caregivers and talking aggressively to staff. A new order from NP to send resident out evaluation was obtained. Non-emergent number for city called to request assistance in his transfer to hospital." During an interview with the Administrator on 5/20/21 at 12:36 PM he was asked if a plan of care was sent to the hospital regarding Resident #6's needs. The administrator stated, "Residents are not sent out to the hospital with care plans." During an interview with the DON she stated, when residents are sent out to the hospital they should have a plan of care sent with them. When asked if Resident #6 have a Plan of Care sent to the hospital on 6/9/20 during his transfer, she stated, "No". A Plan of Care Policy during transfer and discharge was requested during the survey. No Policy was provided prior to exit.	F 622		
F 623 SS=D	Complaint Deficiency Notice Requirements Before Transfer/Discharge	F 623		6/21/21

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F 623	Continued From page 31 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 623	Continued From page 33 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to notify the Ombudsman that 1 of 7 (Resident #6)in the survey sample was being transferred from the facility to the hospital on June 9, 2020. The findings included: Resident #6 was admitted to the facility on 5/21/20 with diagnoses of hypertension, GERD, diabetes, dementia, psychotic disorder, asthma and arthritis. Resident #6 medical records did not include documentation that he Ombudsman's representative was notified of a transfer to the hospital. An Initial Minimum Data Set dated 5/25/20 assessed this resident as having been coded as a (01) on the Basic Interview for Mental Status (BIMS). This resident was assessed (3/2) in the	F 623	F623 1. The State LTC Ombudsman was notified of resident #6 discharge to acute care on 7/16/2020. 2. A complete audit of all discharges from the past 6 months and notifications to Ombudsman has been completed with no new findings. 3. Social Services Director will monitor completeness of the discharge notifications to Ombudsman. Administrator or designee will audit notifications to Ombudsman for completeness for the next 3 months. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.	

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F 623	Continued From page 34 area of bed mobility, (3/3) in the area of transfer, (1/1) in the area of dressing. In the area of Speech this resident was coded as (usually understood) as well as (usually understands others). A Nursing Note dated 06/10/20 at 8:26 AM on June 9, 2020 approximately 1:30 PM it was brought to my attention that resident who is s/p fall day 1, no acute injuries, but has a slight change in mentation, is swatting at caregivers and talking aggressively to staff. A new order from NP to send resident out evaluation was obtained. Non-emergent number for city called to request assistance in his transfer to hospital." During an interview on 05/18/21 at 11:29 AM, with the State Long Term Care Ombudsman he stated, "The facility did not notify his office of a transfer of Resident #6 discharge to a hospital on 06/09/20". During an interview on 05/20/21 at 12:36 PM with the Administrator, he stated, he was not aware a notifications should be sent to the Ombudsman office when a resident is transferred to the hospital. A facility policy and procedure was requested during the survey for Ombudsman Notification for transfer and discharge. The policy and procedure was not provided during the survey.	F 623		
F 625 SS=D	Complaint Deficiency Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		6/21/21

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F 625	Continued From page 35 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide written to the resident or resident representative that specifies the duration of the bed-hold policy, for 1 of 7 residents (Resident #6) in the survey sample. The findings included: Resident #6 was admitted to the facility on 5/21/20 with diagnoses of hypertension, GERD,	F 625	F625 1. Resident #6 was discharged on 6/9/2020 and did not return to the facility. No adverse effect occurred from this deficient practice. 2. All residents who have an unplanned discharge or transfer to acute care are at risk. 3.Reeducation for all licensed direct care staff will be provided on transfer and	

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diabetes, dementia, psychotic disorder, asthma and arthritis. Resident #6 medical records did not include documentation that he or his representative were provided with a Bed-hold notice upon transfer to the hospital.

An Initial Minimum Data Set dated 5/25/20 assessed this resident as having been coded as a (01) on the Basic Interview for Mental Status (BIMS). This resident was assessed (3/2) in the area of bed mobility, (3/3) in the area of transfer, (1/1) in the area of dressing. In the area of Speech this resident was coded as (usually understood) as well as (usually understands others).

A Nursing Note dated 06/10/20 at 8:26 AM on June 9, 2020 approximately 1:30 PM it was brought to my attention that resident who is s/p fall day 1, no acute injuries, but has a slight change in mentation, is swatting at caregivers and talking aggressively to staff. A new order from NP to send resident out evaluation was obtained. Non-emergent number for city called to request assistance in his transfer to hospital."

During an interview on 05/20/21 at 12:36 PM with the Administrator, he stated, he was not aware a Bed Hold notification should be given to the resident or their representative when a resident is transferred to the hospital.

A review of the facility's Bed Hold policy indicated: "It is the policy of the facility to hold the bed of a resident under certain circumstances". "Acknowledgement Statement: I, the undersigned, acknowledge that I have received information regarding the transfer; discharge and bed hold policy of this facility. (Refer to admission

discharge policy and necessary information for the transfer. Director of Nursing or designee will audit 10% of all discharged resident charts to ensure appropriate transfer and discharge documentation.
4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.

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F 625	Continued From page 37 agreement)." I have also been informed of any appeal right that I may have, under either the state or federal guidelines regarding transfer/discharge".	F 625		
F 626 SS=D	Complaint Deficiency Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626		6/30/21

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F 626	Continued From page 38 § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to permit 1 of 7 residents (Resident #6) in the survey sample to return to the facility. The findings included: Resident #6 was admitted to the facility on 5/21/20 with diagnoses of hypertension, GERD, diabetes, dementia, psychotic disorder, asthma and arthritis. Resident #6 was not permitted to return to the facility after being transferred to the hospital. An Initial Minimum Data Set dated 5/25/20 assessed this resident as having been coded as a (01) on the Basic Interview for Mental Status (BIMS). This resident was assessed (3/2) in the area of bed mobility, (3/3) in the area of transfer, (1/1) in the area of dressing. In the area of Speech this resident was coded as (usually understood) as well as (usually understands others). A Nursing Note dated 06/10/20 at 8:26 AM on June 9, 2020 approximately 1:30 PM it was brought to my attention that resident who is s/p fall day 1, no acute injuries, but has a slight change in mentation, is swatting at caregivers and talking aggressively to staff. A new order	F 626	F626 1. 1. Resident #6 was discharged on 6/9/2020 and did not return to the facility. 2. An audit of facility-initiated discharges in has been conducted to ensure there were no instances of not permitting a resident to return to the facility. 3. Education on policy for the Interdisciplinary team will be provided, including readmission requirements. Interdisciplinary team will be educated on documenting discussions of resident□s anticipated return plans within the clinical record. Administrator or designee will audit facility-initiated discharges to ensure compliance. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.	

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from NP to send resident out evaluation was obtained. Non-emergent number for city called to request assistance in his transfer to hospital."

During an interview on 05/20/21 at 12:36 PM with the Administrator, he was asked if the facility could meet Resident #6's needs. The administrator stated, Yes. The administrator was asked if Resident #6 presented behaviors that endangered the safety of others. The administrator stated, No. The administrator was asked if Resident #6 owe the facility back money for no-payment for services. The administrator stated, No. The administrator was asked if Resident #6's health improved sufficiently so that the resident no longer needed the services of the facility. The administrator stated, No.The administrator was asked had the facility ceased to operate. The administrator stated, No.

During an interview on 05/18/21 at 11:29 AM with the State Long Term Care Ombudsman he stated, the facility staff refused to re-admit the resident. The Ombudsman stated, he received a call on 06/10/20 from Resident #6's wife. The wife called stating that her husband was sent to the hospital and the nursing facility refused to take him back.

An Ombudsman Complaint file dated 06/10/20 indicated: "The resident was sent out to the hospital because of a fall. The hospital called the facility today to say the resident is ready to return. They were told that the facility will not take the resident back. When the wife was interviewed the resident's wife, stated that the resident was sent out on 06/09/21 and she was never told so she had trouble finding out the location of the resident; according to the wife. She was not told

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F 626	Continued From page 40 about a bed hold and she is unable to care for the resident at home. Ombudsman (writer of this report) called the facility and spoke to the administrator who said he did not have to take the resident back." During an interview on 5/19/21 at 4:03 PM with the Admission's Director, she was asked why Resident # 6 was not readmitted to the facility. The Admission's Director stated, the wife stated she was taking him home. She was asked if Resident #6 have an un-paid bill ? The Admission's Director stated, (No), he had no outstanding cost and had Medicare and Tri-care Health Insurance." A review of the facility's Bed Hold policy indicated: "It is the policy of the facility to hold the bed of a resident under certain circumstances." "Acknowledgement Statement: I, the undersigned, acknowledge that I have received information regarding the transfer; discharge and bed hold policy of this facility. (Refer to admission agreement)." I have also been informed of any appeal right that I may have, under either the state or federal guidelines regarding transfer/discharge".	F 626		
F 880 SS=D	Complaint Deficiency Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		6/21/21

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 42 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain infection control practices by donning the appropriate PPE (personal protective equipment) prior to entering two of seven sampled resident ' s rooms who were also on quarantine precautions; Resident #1 and #2. The findings included: On 5/18/21 at 12:13 p.m., it was observed that Resident #2 was on quarantine precautions. Resident #2 had pink signage on the wall next to her doorway documenting proper donning and doffing procedures.	F 880	F880 1. OSM #2 and CNA #2 were re-educated on the requirements for PPE for all residents on quarantine or isolation. 2. All residents are at risk if infection control measures are not consistently implemented during direct care or during times when staff are within 3 ft of a resident. 3. Additional education to all direct and non-direct care employees on maintaining infection control practices by donning appropriate PPE prior to entering the room has been provided. All new hires will be trained on current infection control protocols. DON or designee will monitor	

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F 880	Continued From page 43 On 5/18/21 at 12:34 p.m., CNA (Certified Nursing Assistant) #2 walked into Resident #2's room already wearing a face shield and N95 mask. CNA #2 then raised the resident ' s bed by touching the footboard to the bed, donned her gown hanging on a hook in the resident's room and then washed her hands. CNA #2 did not wash her hands prior to donning the gown. CNA #2 then started cutting up Resident #2's food and began assisting the resident with eating (who required full assistance), without wearing gloves. CNA #2 finished assisting the resident with lunch at 12:54 p.m. and did not wear gloves the entire time. Review of Resident #2's clinical record revealed that she was admitted to the facility on 8/10/17 and came back from the emergency room on 5/10/21 with diagnoses that included but were not limited to Alzheimer's disease, high blood pressure, dementia, and diabetes mellitus. Resident #2's most recent MDS (Minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/23/21. Resident #2 was coded as being severely impaired in cognitive function scoring 02 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident ##2 was coded a requiring extensive assistance from one staff with meals. Review of Resident #2's COVID -19 vaccination status revealed that she received her second vaccination on 2/10/21. Review of the COVID -19 testing logs revealed that Resident #2 had tested negative for COVID-19 on 5/16/21.	F 880	compliance during daily round x 8 weeks. 4. Results of all audits will be presented to the QAPI Committee for additional oversight and recommendations.	

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On 5/18/21 at 12:13 p.m., it was observed that Resident #1 was on quarantine precautions. Resident #1 had pink signage on the wall next to her doorway documenting proper donning and doffing procedures of PPE.

On 5/18/21 at 12:48 p.m., OSM (Other Staff Member) #2, maintenance staff entered Resident #1's room wearing just a face shield and an N95 mask. OSM #2 was observed fixing the call light system directly over Resident #1's bed. Resident #1 was also in bed at this time. OSM #2 was approximately an inch from the resident's bed and side rail, almost touching the side rail was his arm. OSM #2 was not wearing a gown or gloves. At 12:51 p.m., OSM #2 left the room and stated to Resident #1 that he would be right back. OSM #2 did not sanitize his hands prior to leaving the room. OSM #2 then left the unit. It was observed that OSM #2 had left his power drill on the resident's bedside table with no barrier between the table and drill.

On 5/18/21 at 1:00 p.m., OSM #2 had re-entered Resident #1's room without sanitizing his hands prior. OSM #2 was again wearing his face shield and N-95 mask only. OSM #2 went back to fixing the call light system directly over Resident #1's bed. OSM #2 was standing approximately an inch or less from Resident #1's bed.

Resident #1 was admitted to the facility on 11/26/18 and readmitted to the facility on 5/11/21 from the hospital with diagnoses that included but were not limited to cancer, anemia, heart failure, and high blood pressure. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/11/21. Resident #1 was coded as being

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cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #1's COVID -19 vaccination status revealed that she received her second vaccination on 2/10/21.

Review of the COVID -19 testing logs revealed that Resident #1 had tested negative for COVID-19 on 5/16/21.

On 5/18/21 at 12:55 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #4, the LPN on duty. When asked the appropriate PPE staff should be wearing before entering a room of a resident on quarantine, LPN #4 stated that staff should already be wearing their N95 masks and face shields so they should be donning a gown and a pair of gloves. When asked if staff should also be wearing a gown and pair of gloves when fully assisting a resident with meals on the quarantine, LPN #4 stated that staff should be because they are providing direct care. When asked if staff should be sanitizing their hands prior to leaving the resident's room on quarantine precautions, LPN #4 stated that they should be. When asked if gowns were only worn if providing direct patient care for a resident on quarantine, LPN #4 stated, "I am not sure, let me get back to you."

On 5/18/21 at 1:01 p.m., LPN #4 stated that gowns and gloves were only required for direct patient care even for residents on quarantine. LPN #4 stated that she received this information from the DON (Director of Nursing). When asked if a gown was required if staff were in close proximity to the resident and the resident's bed,

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LPN #4 stated that she wasn't sure how to answer that question. This writer took the LPN #4 to Resident #1's room, while OSM #2 was still standing less than an inch away from Resident #1's bed without a gown or gloves on. LPN #4 confirmed the observation and stated she would have to check to see if a gown or gloves were required while standing that close to the resident ' s bed.

On 5/18/21 at 1:05 p.m., LPN #4 stated that she checked with the DON again stated that staff only needed to wear a gown and gloves if providing direct patient care

On 5/18/21 at 1:20 p.m., an interview was conducted with ASM #2, the DON. When asked what PPE was required when working with a resident on quarantine, ASM #2 stated that if staff are providing direct patient care to a quarantine resident, they should be wearing "a gown, gloves, mask and face shield." ASM #2 stated the same PPE should be worn while assisting a quarantine resident with their meal because it is considered "Direct Patient Care." When asked if a gown or gloves are required if they are standing in close proximity to the resident and the resident's bed, ASM #1, the facility administrator stated that they have always educated their staff if providing direct patient care gowns and gloves are to be worn. ASM #1 and ASM #2 were made aware of the above observation with OSM #2. ASM #1 then stated that the facility didn't think about other staff going into rooms; that that was something they needed to look into.

On 5/18/21 at 3:00 p.m., an interview was conducted with OSM #2, the maintenance worker. When asked if he was fixing the call bell

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F 880	Continued From page 47	F 880		

system in Resident #1's room that day, OSM #2 stated that he was. When asked if this resident was on quarantine precautions, OSM #2 stated that she was. When asked what should be worn prior to entering a resident ' s room who is on quarantine precautions; OSM #2 stated that a face shield, mask and gown should be worn prior to entering the room. OSM #2 then stated if doing direct patient care; staff should be wearing a gown; which he does not provide direct patient care. When asked if a gown or gloves should be worn if a staff member is in close proximity to a resident on quarantine, OSM #2 stated "Yes, probably if he was within 3 feet from the resident." When asked if he was wearing a gown or gloves while fixing the resident ' s call bell, OSM #2 stated that he was not. When asked why he should don a gown and gloves within three feet from the resident, OSM #2 stated because the resident could be infected with COVID-19. When asked if the facility was treating quarantine residents as if they had COVID-19, OSM #2 stated that they were.

On 5/20/21 at 11:34 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the infection control preventionist. When asked why Resident #1 and Resident #2 were on quarantine, LPN #1 stated that all new admissions or readmissions were on quarantine. When asked the type of precautions Residents on quarantine would be put on, LPN #1 stated, "Droplet Precautions for 14 days." When asked if staff should be wearing full PPE prior to entering the rooms of resident's on quarantine, LPN #1 stated, "Staff should be dressing in Full PPE prior to entering the room." LPN #1 stated that the facility should be treating the residents as if they have COVID even if fully vaccinated. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION AND NURSING	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 stated that Resident #1 and Resident #2 did receive their vaccinations. Facility policy titled, "Emergency Pandemic Policy" documents in part, the following: "For a resident on contact precautions: staff don gloves and isolation gown before contact with the resident and his or her environment...For a resident on droplet precautions...staff don a facemask within 6 feet from a resident...For a resident on airborne: staff don an N95 or higher level respirator prior to room entry...For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N-95 or higher level respirator if available."	F 880		