STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 11/19/20 and continued offsite on 11/20/20 and 11/23/20. Three complaints were investigated during the course of survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 136 ceritfied bed facility was 113 at the time of survey. The survey sample consisted of three closed records (Resident #1,#3, #4) and one current record (Resident #2).	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews, medical record review, facility document review, hospital record review, and emergency medical services record review, the facility staff failed to provide the assessed feeding need of supervision with one person physical support for 1 resident during lunch on 9/29/2020 that resulted in the resident choking on a piece of chicken, which constitutes harm for 1 of 4 residents in the survey sample, Resident #1. The findings included:	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/16/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 1	F 689		

Resident #1 was admitted to the facility on 10/17/18 with diagnoses to include but not limited to Generalized Muscle Weakness, Diabetes Mellitus, Major Depressive Disorder, Moderate Mental Retardation and Dementia.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 7/6/20. The Brief Interview for Mental Status was coded as a 7 out of a possible 15 indicating Resident #1 was severely cognitively impaired. Under Section G0110 Activities of Daily Living (ADL) Assistance; (H.) Eating, Resident #1 was coded under 1. ADL Self Support as a 1=Supervision-oversight, encouragement or cueing. Under 2. ADL Support Provided Resident #1 was coded as 2=One person physical assist. Under Section G0400 Functional Limitation in Range of Motion (Code for limitation that interfered with daily functions or placed resident at risk of injury); A. Upper extremity (shoulder, elbow, wrist, hand) Resident #1 was coded as 2=Impairment on both sides.

The following Minimum Data Sets for Resident #1 were reviewed and are documented in part, as follows:

Quarterly with an Assessment Reference Date (ARD) of 4/17/20. Under Section G0110 Activities of Daily Living (ADL) Assistance; (H.) Eating, Resident #1 was coded under 1. ADL Self Support as a 1=Supervision-oversight, encouragement or cueing. Under 2. ADL Support Provided Resident #1 was coded as 2=One person physical assist. Under Section G0400 Functional Limitation in Range of Motion (Code for limitation that interfered with daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 2	F 689		

functions or placed resident at risk of injury); A. Upper extremity (shoulder, elbow, wrist, hand) Resident #1 was coded as 2=Impairment on both sides.

Quarterly with an Assessment Reference Date (ARD) of 1/16/20. Under Section G0110 Activities of Daily Living (ADL) Assistance; (H.) Eating, Resident #1 was coded under 1. ADL Self Support as a 3=Extensive assistance Under 2. ADL Support Provided Resident #1 was coded as 2=One person physical assist. Under Section G0400 Functional Limitation in Range of Motion (Code for limitation that interfered with daily functions or placed resident at risk of injury); A. Upper extremity (shoulder, elbow, wrist, hand) Resident #1 was coded as 2=Impairment on both sides.

Comprehensive Annual with an Assessment Reference Date (ARD) of 10/16/19. Under Section G0110 Activities of Daily Living (ADL) Assistance; (H.) Eating, Resident #1 was coded under 1. ADL Self Support as a 1=Supervision-oversight, encouragement or cueing. Under 2. ADL Support Provided Resident #1 was coded as 2=One person physical assist. Under Section G0400 Functional Limitation in Range of Motion (Code for limitation that interfered with daily functions or placed resident at risk of injury); A. Upper extremity (shoulder, elbow, wrist, hand) Resident #1 was coded as 2=Impairment on both sides.

Resident #1's Comprehensive Care Plan with the last facility review being 7/12/20 was reviewed and is documented in part, as follows:

Focus:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 3	F 689		

Name (Resident #1) has self-care deficit and requires assistance with ADL's related to mobility status.
Date Initiated: 06/04/2018
Revision on: 02/05/2019

Goal:
Resident needs will be met.

Interventions:
Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care.
Date Initiated: 06/04/2018

Focus:
Name (Resident #1) has a potential for nutritional problem and dehydration/fluid intake issues related to po (by mouth) intake.
Date Initiated: 02/05/2019
Revision on: 05/08/2019

Goal:
The resident will maintain adequate nutritional status.

Interventions:
Assess/document/report to Nursing/MD (medical doctor) PRN (as needed) for s/s (signs and/or symptoms) of dysphagia (difficulty swallowing): Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals, etc.
Date Initiated: 02/05/2019

On 11/19/2020 at 1:30 P.M. a phone interview was conducted with the facility MDS Coordinator RN (Registered Nurse) #1 regarding Resident #1. MDS Coordinator RN #1 was asked to review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 4	F 689		

Resident #1's Quarterly MDS with the ARD date of 7/6/20 under Section G0110 Activities of Daily Living (ADL) Assistance; (H.) Eating and to tell the Surveyor how Resident #1 was coded. MDS Coordinator RN #1 stated, "The resident was coded as requiring supervision with one person physical support 1/2." This surveyor asked MDS Coordinator RN #1 to explain what that meant. MDS Coordinator RN #1 stated, "She would need one person supervising her, someone would need to be with her the whole time she was eating ." MDS Coordinator RN #1 was asked if Resident #1 was alone eating lunch on 9/29/20 and choked would that be considered as having supervision with one person physical support. MDS Coordinator RN #1 stated, " No, if she was alone she was not being supervised."

Resident #1 current Physician Orders for September 2020 were reviewed and are documented in part, as follows:

Dietary-Diet:
Cardiac/LCS (low concentrated sweets) diet
Regular texture, Thin consistency, NO ADDED SALT
Order Date: 10/12/2018

Resident #1's facility Dietary Preference Sheet was reviewed and is documented in part, as follows:
Lunch:
Dining Location: Eats In Room
Diet Order: Regular, Cardiac, LCS

Alerts:
Dislikes: >Chicken (Bone-In Chicken Breast), >Coffee, >Carrots (Unless in soup)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 5	F 689		

The facility's Menu for lunch on 9/29/20 was reviewed and is documented in part, as follows:

Resident's Choice: Fried Chicken, Macaroni and Cheese, Lima Beans, Dinner Roll, Margarine, Cream Pie, Beverage of Choice.

Resident #1's Progress notes on 9/29/2020 were reviewed and are documented in part, as follows:

9/29/2020 14:36 P.M. SBAR (Situation-Background-Assessment-Recommend ation) Summary for Providers completed by LPN (Licensed Practical Nurse) #1.

Situation: The Change in Condition reported on this Evaluation are/were: Loss of consciousness (syncope) Shortness of breath.

At the time of evaluation resident/patient vital signs, weight and blood sugar were:
Blood Pressure: BP 205/88-9/29/2020 16:01
Position: Sitting right/arm
Pulse: P 81-9/29/2020 16:01 Pulse Type: Regular
RR(Respirations): R 18.0-9/28/2020 14:38
Temperature: T 103.4-9/29/2020 12:15 Route: Oral
Weight: W 192.4lb (pounds)-9/2/2020 14:17
Scale: Mechanical lift scale
Pulse Oximetry: 02 (oxygen) 57%-9/29/2020 16:03 Method: Oxygen via Mask
Blood Glucose: BS 240.0-9/29/20 09:10

Outcomes of Physical Assessment:
Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse).
Functional Status Evaluation: No changes observed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 6	F 689		

Respiratory Status Evaluation: Labored or rapid breathing. Abnormal lung sounds (rales, rhonchi, wheezing).
Cardiovascular Status Evaluation: (Blank)
Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse).

Nursing observations, evaluations, and recommendations are: Resident observed by staff in respiratory distress. Resident is DNR/CC (Do Not Resuscitate/Comfort Care). Mouth sweep produced piece of unchewed chicken. Staff suctioned excessive amount of mucous and phlegm from airway. Nebulizer administered, 02 increased to 5 liters via non rebreather, vs (vital signs) obtained 205/85-101.4-81. 02 sats. 57%. Family notified and stated to send resident to er (emergency room) for evaluation. Call placed to 911. EMS (Emergency Medical Services) in building to transport to ER.

Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send to ER for evaluation.

9/29/2020 15:50 P.M. Nursing Note: Resident observed by staff in respiratory distress. Resident is DNR/CC. Mouth sweep produced piece of unchewed chicken. Staff suctioned excessive amount of mucous and phlegm from airway. Nebulizer administered, 02 increased to 5 liters via non rebreather, vs obtained 205/85-101.4-81. 02 sats. 57%. Family notified and stated to send resident to er for evaluation. Call placed to 911. EMS in building to transport to ER.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 7	F 689		

9/29/2020 15:54 P.M. Nursing Note: Received call from ER that resident expired. Name (Medical Doctor) notified.

9/29/2020 18:11 P.M. Late Entry Nurses Note: The resident's needs cannot be met at this time due to SEE SBAR, after facility attempts to meet the resident needs. The services available at receiving facility can meet the resident's immediate needs at this time. D/C (Discharged) at this time to SEE SBAR. Resident D/C with copies of face sheet, copy of advanced directive, order summary, care plan, D/C summary, bed hold policy, transfer notice. Per family request, resident was to be sent out.

Resident #1's Emergency Medical Service's Response/Run sheet dated 9/29/2020 was reviewed and is documented in part, as follows:

Call Type: Unconscious/fainting/Near Fainting
Response Mode: Emergent (Immediate Response)
Urgency: Immediate

Response Times:
PSAP(Public safety Answering Point): 09/29/2020 14:32:14
Unit Dispatched: 09/29/2020 14:32:39
Enroute: 09/29/2020 14:33:46
At Scene: 09/29/2020 14:37:13
At Patient: 09/29/2020 14:39:44
Depart: 09/29/2020 14:46:21
Arrive Destination: 09/29/2020 14:53:45

Provider Impression: Neuro-Unconscious
Secondary: Respiratory
Impression: Acute Onset Distress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 8	F 689		

Patient Condition:
Complaint Type: Chief (Primary)
Complaint: unconscious
Duration: 10 Minutes
Primary Symptoms: Mental Status is unresponsive
Other Symptoms: Respiratory arrest

Assessment Summary:
Skin: warm
Mental Status: Unresponsive

Interventions:
9/29/2020 14:44:44 Assist Ventilation-BVM (bag valve mask) Via Mask and Insertion-Oropharyngeal Airway

Vitals:
09/29/2020 14:46:44 Blood Pressure: 210/108, Pulse: 50, Respirations: 12 Assisted Ventilations, Oxygen Saturation: 88% on High Concentration 02 (10-25 LPM), GCS (Glasgow Coma Scale): 3= (Totally Unresponsive), No eye movement when assessed, No motor response, No verbal/vocal response.

09/29/2020 14:55:44 Blood Pressure: 198/106, Pulse: 56, Respirations: 12 Assisted Ventilations, Oxygen Saturation: 88% on High Concentration 02 (10-25 LPM), GCS (Glasgow Coma Scale): 3= (Totally Unresponsive), No eye movement when assessed, No motor response, No verbal/vocal response.

Cardiac Arrest: No

Narrative:
On location found patient lying supine in bed unconscious and unresponsive. Nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 9	F 689		

stated patient was eating and began to choke then aspirated. Patient did have a non-rebreather mask on. Nursing staff stated patient did have a history of diabetes, and dementia. When asked staff was unable to give current glucose level of patient. Nursing staff stated patient was eating and began to choke then aspirated. Staff removed food from her mouth then placed on high flow oxygen. Patient had gone unconscious after aspirating. At that time EMS was notified. On location found patient unresponsive with a GCS of 3. Patient had shallow breathing rate of 12 times a minute. Patients skin was warm to touch with a weak pulse. Rapidly placed patient on stretcher. Nurse stated patient had a full DNR (Do Not Resuscitate), crew went to load patient into unit while I went to nursing station to receive paperwork. After several minutes of waiting and conflicting stories, the facility was unable to produce any form of DNR. One staff member stated that in an advanced directive form that the family wanted all life saving measures done. with the confusion and length of time of not being able to provide paperwork I returned to the unit to continue patient care. During transport patients vitals continued to diminish and was unable to maintain her airway. Patient started breathing at a rate of 4-6 times a minute with a oxygen saturation of 78%. I placed an oral airway successfully, then used bag valve mask with high flow oxygen to assist with ventilation. I took patient vital signs again and oxygen saturation has improved. Arrived at Name (Hospital) unloaded patient while continuing assisted ventilation. Once in the ED (Emergency Department) staff informed us that the nursing facility had found and sent a current copy of the DNR; at that time all life saving resuscitation was stopped. Placed patient in bed 1. Patient was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 10	F 689		

pronounced dead in the ED by the Physician.

Resident #1's Physician History and Physical/Progress Note signed 10/1/2020 was reviewed and is documented in part, as follows:

Effective Date: 09/29/2020 13:38 P.M.
Type: Discharge
Chief Complaint:
Discharge: 82 y.o. (year old) female here for LTC (Long Term Care). Staff reported resident having high grade fever and chills. COVID test was negative. UA (urinalysis) was abnormal. C&S (culture and sensitivity) was sent and Rocephin 2 gm IM was given. Late on she looked better and was eating lunch and got choked on a piece of chicken. Per nurses note finger sweep was done and suction phlegm was done. Family requested to send to ER. Facility received call from ER and she expired in transit. Cause of death: 1. Cardiac Arrest due to Coronary Atherosclerosis exacerbated by Aspiration and UTI (urinary tract infection). she was pronounced at transit to ER.

Resident #1's Emergency Department Provider Notes dated 09/29/2020 at 3:15 P.M. were reviewed and are documented in part, as follows:

History and Physical :
Patient is an 82-year-old female with multiple medical problems from the nursing home. According to EMS they were feeding her and they believe that she choked or aspirated. When EMS got there her saturations were low, her respiratory rate gradually declined. The nursing home staff felt that she was a DNR. She was placed into the ambulance, gradually had decrease in respiratory effort, agonal respirations. She arrived here with no pulse, no respiratory effort and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 11	F 689		

resuscitation was stopped at 2:58 p.m. There was a valid do not resuscitate order that was faxed to us indicating comfort measures only.

Review of Systems:
Patient unresponsive

Physical Exam: Vital signs and nursing note reviewed.
Constitutional: General: She is in acute distress. Comments: Unresponsive, agonal respirations that stopped. No pulse.
HENT (head, eyes, nose throat): Mouth/Throat: Comments: Some mucus from the mouth.
Cardiovascular: Comments: No pulse.
Pulmonary: Comments: No respiratory effort.
Abdominal: Comments: Abdomen is flat.
Skin: Comments: Skin is warm.
Neurological: Comments: Unresponsive

Clinical Impression:
Cardiac arrest, Aspiration into respiratory tract, initial encounter.

Resident #1's Certified Nursing Assistant Documentation Survey Reports for ADL-Eating for the months of July 2020, August 2020, and September 2020 were reviewed and are documented in part, as follows:

July 2020 ADL-Eating 0900 A.M. documentation was missing for 7/4, 7/7, 7/10, 7/11, 7/12, 7/13, 7/18, 7/21, 7/22, 7/24, 7/25, 7/26, 7/29, 7/30, and 7/31.

July 2020 ADL-Eating 1:00 P.M. documentation was missing for 7/4, 7/7, 7/10, 7/11, 7/12, 7/13, 7/18, 7/21, 7/22, 7/24, 7/25, 7/26, 7/29, 7/30, and 7/31.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 12	F 689		

July 2020 ADL-Eating 6:00 P.M. documentation was missing for 7/3, 7/12, 7/21, 7/22, 7/24, 7/25, and 7/31.
Out of 93 documentation opportunities for ADL-Eating Documentation in July 2020 there were 37 areas of undocumented care provided to Resident #1.

August 2020 ADL-Eating 0900 A.M. documentation was missing for 8/1, 8/2, 8/4, 8/6, 8/9, 8/10, 8/13, 8/14, 8/15, 8/16, 8/22, 8/23, 8/25, 8/27, and 8/29.

August 2020 ADL-Eating 1:00 P.M. documentation was missing for 8/1, 8/2, 8/4, 8/6, 8/9, 8/10, 8/13, 8/14, 8/15, 8/16, 8/19, 8/22, 8/23, 8/25, 8/27, and 8/29.

August 2020 ADL-Eating 6:00 P.M. documentation was missing for 8/4, 8/5, 8/8, 8/9, 8/12, 8/13, 8/14, 8/17, 8/18, 8/22, 8/23, and 8/28.
Out of 93 documentation opportunities for ADL-Eating Documentation in August 2020 there were 43 areas of undocumented care provided to Resident #1.

September 2020 ADL-Eating 0900 A.M. documentation was missing for 9/2, 9/4, 9/5, 9/6, 9/7, 9/8, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/21, 9/22, 9/23, 9/25, 9/26, 9/27, 9/28 9/29 and 9/30.

September 2020 ADL-Eating 1:00 P.M. documentation was missing for 9/2, 9/4, 9/5, 9/7, 9/8, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/21, 9/22, 9/23, 9/25, 9/26, 9/27, 9/28 9/29 and 9/30.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 13	F 689		

September 2020 ADL-Eating 6:00 P.M. documentation was missing for 9/2, 9/11, 9/15, 9/16, 9/20, 9/22 and 9/26.

Out of 89 documentation opportunities for ADL-Eating Documentation in September 2020 there were 52 areas of undocumented care provided to Resident #1.

A Telemedicine Visit with Medical Oncology dated 6/18/2020 for Resident #1 was reviewed and is documented in part, as follows:

History of Present Illness:
Oncology History: 12/10/2012 History of colon cancer. 1/11/2013 Surgery Colon resection the right side.

Name (Resident #1) is a 81 year old female who is called for a telephone follow up of colon cancer. She complains of pain. She tells me that she takes a pain pill twice a day. She has lost her teeth and has broken her glasses. She is currently eating soft foods. She states that she has lost some weight. The patient does not have any co-morbidities or personal/family issues that complicate her care.

On 11/19/2020 at 12:10 P.M. a phone interview was conducted with Unit Manager (UM) LPN #4 regarding her involvement of Resident #1 on 9/29/2020. UM LPN #4 stated, "Around 9 A.M. she had an acute issue and complained of chills and low grade fever, we assessed her Name (LPN #1) and I. She was put on isolation precautions and a Rapid Covid test was done and was negative. We also had an order to test her for the flu which if negative we were to obtain a urinalysis. We dipped her urine in house and it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 14	F 689		

showed a large amount of leukocytes. Her fever spiked to 102.9 and the doctor ordered Rocephin and she perked up. I left early that day so I wasn't here when she choked but LPN #1 and LPN #3 were. I discussed with Name (LPN #1) the day after about what happened. LPN #1 said she had fed her macaroni and cheese and lima beans when she went to check on her with no issues. She then was called to the room because resident was choking on a piece of chicken.. LPN #1 cleared the chicken out of her mouth and suctioned her."

On 11/19/2020 at 12:17 P.M. a phone interview was conducted with LPN #3 regarding her involvement with Resident #1 on 9/29/2020. LPN #3 stated, "A lady called me 2 weeks ago and said your the one, she questioned me if I knew if it was true that Name (Resident #1) choked on a chicken bone. I told her that there was no bone in the chicken that was in her mouth, that the chicken had been took off the bone. I was on the other hallway that day when I saw and heard Name (LPN #1) running with the suction machine and hollering for help. She said the Name (Resident #1) was not breathing. I ran to Name (Resident #1's) room and she was up in bed and looked like she was struggling to get a breath. Her eyes were half shut, I called her name but she didn't respond. It looked like chicken was in her mouth so I grabbed a glove and did a finger sweep and got the chicken that was inside her mouth and on her tongue. It was about the size of a quarter and a ball of chicken on her tongue. There was a lot of phlegm, we suctioned her and she took a breath. There was no more chicken in her mouth. I never saw her with teeth, Name CNA (Certified Nursing Assistant) #6 was her CNA. Name (Assistant DON) and I ran to start

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 15	F 689		

the paperwork, Name (Resident #1) was not coherent. We called 911 and she left on the stretcher."

On 11/19/2020 at 12:33 P.M. a phone interview was conducted with LPN #1 regarding her involvement with Resident #1 on 9/29/2020. LPN #1 stated, "I was the charge nurse that day. That morning Name (Resident #1) was cold and shivering. I took her vitals and made the doctor aware. Her temperature went up to 103 and I did a urinalysis and called the doctor. The doctor said to give her Rocephin 1 gram and to check her in an hour and call him back. I went to check on her around 1:30. I fed her some lima beans and some macaroni and cheese and pulled her chicken apart. She feeds herself after her tray is setup and she is on a regular diet. She always eats in her room rarely gets out of bed. After I made her comfortable I left the room and went back to the nurses station to do some charting. The next thing I heard was Name (Housekeeper) yelling, "I think she is choking," referring to Name (Resident #1). I ran to Name (Resident #1's) room , sat her up, gave her 2 pats to her back, she coughed. There was a lot of phlegm and chicken. There was a quarter size piece of chicken that wasn't chewed and a lot of drool and phlegm. Name (CNA #6) stayed with her and I ran to get the crash cart for the suction machine. I yelled for Name (LPN #3) to come help and the Assistant Director of Nursing also came to the room. She (Resident #1) was deteriorating, I suctioned a lot of phlegm out of her mouth and Name (LPN #3) did a quick mouth sweep and got a small piece of chicken out. Name (LPN #3) left the room to call the family. Name (Resident #1's) oxygen saturations dropped and her eyes were rolling back in her head. I put oxygen on her via a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 16	F 689		

nasal cannula at 4 lpm then switched to a non-rebreather mask at 8 lpm. EMS arrived and told them what was going on and that family wanted her to go to the ER. The hospital called and said she had expired."

On 11/19/2020 at 12:55 P.M. a phone interview was conducted with CNA #6 regarding Resident #1 on 9/29/2020 and the assistance provided to the resident during meals. CNA #6 stated, "I'm the normal CNA for the unit. For Name (Resident #1) we just set her tray up, open things and she feeds herself. On the day she choked I heard Name (Housekeeper) yelling Name (Resident #1) is choking. So I hollered for Name (LPN #1) to come help. Name (LPN #1) set her up and hit her on her back to get food and phlegm up. Name (LPN #1) went to get the crash cart for the suction machine. I stayed in the corner out of the way."

On 11/19/2020 at 1:22 P.M. a phone interview was conducted with the Housekeeper regarding her involvement with Resident #1 on 9/29/2020. The Housekeeper stated, "I go to see her (Resident #1) everyday. I went to her room that day to put her clothes away and saw she was on oxygen. I spoke to her, she didn't speak at all, I figured she was not feeling good She usually says "Hey Girl". Her lunch tray was in front of her, she had been feeding herself. I noticed that she had spilt her juice and tea all over her tray, fluids were spilled in her food. I said "You don't feel good" and she just kept looking at me. I left for a good 5 to 7 minutes to take the linen cart back and get my cleaning cart. As I was coming back down the hall with my cart I heard someone going "UGH, UGH!" real loud near Name (Resident #1's) room. I thought it was the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 17	F 689		

roommate because she has a deep voice. I walked in the room and asked the roommate if she was ok and she said she was. Then I saw Name (Resident #1) was slumped over to the side, she was not sitting up like usual. Her eyes were weak and she was gagging. I looked at Name (Resident #1) and saw chicken coming back out of her mouth. She was choking bad, scared me so bad. I ran up to the nurses desk and said Name (Resident #1) choking. The nurse came running down. I knew something was not right because her tray was a mess and I saw the chicken coming out of her mouth. I'm not allowed to touch her. There was noting I could do but hurry and get help." Surveyor asked the Housekeeper if they were any other staff in the room assisting Resident #1 with her lunch the two times she entered the room. The Housekeeper stated, "No, there were no staff in the room."

On 11/23/2020 at 7:57 A.M. a phone interview was conducted with the facility Medical Director who was also Resident #1's Attending Physician. The Medical Director was made aware of Resident #1's assessed need of requiring supervision with one person physical support for eating and based on that resident assessment what would he expect for his resident. The Medical Director stated, "Someone should have been there with her, I was not aware she was alone." The Medical Director was also asked if he was aware that on 9/29/20 Resident #1 was found choking on chicken prior to being sent out via 911. The Medical Director stated, "Yes, they did tell me she was choking. She has had a decline/getting worse over the last 6 months. Let me tell you COVID is an issue, the staff are exhausted and they are doing the best they can." On 11/23/2020 the Medical Director asked to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 689	Continued From page 18	F 689		

speak with this surveyor again so at 8:06 A.M. another phone interview with the Medical Director was conducted. The Medical Director stated, "I just spoke with Name (Assistant Director of Nursing) and she said Name (Resident #1) had no history of choking and that the episode on 9/29/2020 was a one-time episode."

On 11/23/2020 at 12:28 P.M. a phone exit briefing was conducted with the Administrator and the above findings were shared. The Administrator was asked what was the purpose of the MDS. The Administrator stated, "It is what we are supposed to go by for the resident care. It tells us what we need to assist or not assist the resident with. The Administrator was asked for any facility polices for staff assisting residents with meals based on MDS coding.

The Administrator emailed this surveyor with the following statement which is documented in part, as follows:

There was no policy on assistance with feeding or supervision. We would performing the task according to how the resident is coded on the MDS according to the RAI (Resident Assessment Instrument) manual.

No further information was received and the survey was concluded.

Complaint deficiency.