State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 11/09/21 through 11/10/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 120 licensed bed facility was 79 at the time of the survey. The survey sample consisted of 8 current Resident reviews (Residents 1 through 8).	F 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff failed to be in compliance with the following Regulations for the Licensure of Nursing Facilities: 12VAC5-371-140 (E) (3) (B). Policies and Procedures. 12VAC5-371-150 (B.1) (G) (H). Resident Rights. 12VAC5-371-220 (C.1). Nursing services. 12VAC5-371-220 (D) (F). Quality of Care. 12VAC5-371-250 (I). Resident Assessment and Care Planning . 12VAC5-371-300 (D H). Pharmaceutical services. 12VAC5-371-340 (D-B.C). Dietary and food services. 12VAC5-371-140 (E) (3) (B). Based on employee record review, facility document review and staff interviews the facility staff failed to ensure that Virginia State Police criminal background checks were obtained for (3) three current employees within 30 days of their	F 001	1.Employee #1 hired on 8/03/21 had a criminal background check that was completed on 3/07/21. Employee #2 hired 9/23/21 had a completed background check conducted 11/09/21.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm. Director — (X6) DATE: 12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 1 hire date. The findings included: On 11/10/21 twenty-five current employee records were reviewed. The employee record review revealed that 2 current employees did not have a Virginia State Police criminal background check within 30 days of hire. Employee #1 was hired on 8/03/20 had already received her criminal background check on 3/07/20 (5 months prior to employment at the facility). Employee #2 was hired on 9/23/21 received her criminal background check on 11/09/21. On 11/10/21 at approximately, 3:20 p.m., an interview was conducted with the Human Resources Manager concerning employee background checks. She stated, "I'm unable to find the original background checks from the hire date. Going forward I will use a log to keep track of the new hire background check." A criminal background check policy was ask for but was not given. On 11/10/21 at approximately 3:55 PM., the above findings were discussed with Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 12 VAC 5-371-150 (B.1) Resident Rights. Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to send a copy of the Resident's Care Plan for 1 out of 8 residents (Resident #2) and failed send a copy of the Bed-Hold Policy upon	F 001	2. Facility staff hired will have a criminal background check within 30 days of employment and in accordance with State Law. 3. Human Resource Manager has been reeducated by the Director of Nursing on obtaining criminal background check within 30 days of hire. A tracking that will be maintained by Human Resource Manager to monitor of new hire dates and completion of criminal background checks within 30 days of hire weekly x3 months. 4. Results of audits will be reviewed in monthly/quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed. 5. AOC date 12/15/21. 1. Resident #2 was transferred to the hospital on 12/04/21 to the ER with a copy of bed hold policy care plan medication list and acute transfer summary.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 2 discharge/transfer for 1 of 8 residents (Resident #2) after being transferred to the hospital. The findings included: 1. The facility staff failed to ensure Resident #2 was provided with a Care Plan notification when discharged to the hospital. Resident #2 was readmitted to the facility on 10/05/21 with diagnoses which included depression, anxiety, restlessness, agitations, paranoid schizophrenia and intellectual disability. A review of the clinical records for Resident #2 indicated she was sent out to the hospital on the following dates: On 10/04/21 Resident #2 was sent to the hospital for left foot infection, psy evaluation and agitation. Resident #2 was readmitted to the facility on 10/04/21 with new medications and treatments. On 10/05/21 Resident #2 was sent to the hospital for infected chronic wound, osteomyelitis, sepsis, and bacteremia. Resident was also evaluated for intermittently combative behavior for psychiatric hospitalization. On 08/06/21 Resident #2 was sent to the hospital for uncontrolled bleeding of right foot. As well as cellulitis of left lower limb and agitation. Resident #2 was re-admitted to the facility on 08/17/21. On 07/13/21 Resident #2 was sent to the hospital for Hypo-osmolality and hyponatremia and altered mental status. On 03/07/21 Resident #2 was sent to the hospital for severe sepsis without septic shock, acute respiratory failure, and altered mental status.	F 001	2. Residents who transferred to the hospital will be provided with a bed hold policy and care plan notification. 3. Facility Nursing staff will be reeducated by Director of Nursing/designee on documentation and providing a bed hold policy and care plan notification when transferring to the hospital medical records of residents who are transferred to the hospital will be reviewed by licensed nurse upon transfer for bed hold policy and care plan notification x 3 months. 4. Results of audits will be reviewed in the monthly/quarterly Qapi meeting. Any discrepancies will be addressed immediately and reeducation provided as needed. 5. AOC date 12/15/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 3 A request for Bed Hold Notifications and Care Plan transfer documentation being sent to the hospital was made to the MDS Coordinator at 11:15 a.m. on 11/11/21. The MDS Coordinator provided an Acute Care Transfer Document Checklist form dated 10/08/21 which indicated the following: "Copies of Documents Sent with Resident (check all that apply) Documents Recommended to Accompany Resident Resident Transfer Form Face Sheet Current Medication list or Current MAR SBAR and/or other Change in Condition Progress Note (if completed) N/A was checked -In the area of Advance Care Orders (POLST, MOLST, POST, Others) Send These Documents if available: Most Recent History and Physical Recent MD/NP/NP and Specialist Orders Flow Sheets (e.g. diabetic, wound care) Relevant Lab results (form the last 1-3 months) Relevant x-rays and other Diagnostic Test Results. No other documentation was provided. The MDS Coordinator stated, she did not have any other documentation. 2. The facility staff failed to ensure Resident #2 was provided with a bed hold notification when discharged to the hospital. Resident #2 was readmitted to the facility on 10/05/21 with diagnoses which included depression, anxiety, restlessness, agitations, paranoid schizophrenia and intellectual disability.	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 4 A review of the clinical records for Resident #2 indicated she was sent out to the hospital on the following dates: On 10/04/21 Resident #2 was sent to the hospital for left foot infection, psy evaluation and agitation. Resident #2 was readmitted to the facility on 10/04/21 with new medications and treatments. On 10/05/21 Resident #2 was sent to the hospital for infected chronic wound, osteomyelitis, sepsis, and bacteremia. Resident was also evaluated for intermittently combative behavior for psychiatric hospitalization. On 08/06/21 Resident #2 was sent to the hospital for uncontrolled bleeding of right foot. As well as cellulitis of left lower limb and agitation. Resident #2 was re-admitted to the facility on 08/17/21. On 07/13/21 Resident #2 was sent to the hospital for Hypo-osmolality and hyponatremia and altered mental status. On 03/07/21 Resident #2 was sent to the hospital for severe sepsis without septic shock, acute respiratory failure, and altered mental status. A request for Bed Hold Notifications and Care Plan transfer documentation being sent to the hospital was made to the MDS Coordinator at 11:15 a.m. on 11/11/21. The MDS Coordinator provided an Acute Care Transfer Document Checklist form dated 10/08/21 which indicated the following: "Copies of Documents Sent with Resident (check all that apply) Documents Recommended to Accompany	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 5 Resident Resident Transfer Form Face Sheet Current Medication list or Current MAR SBAR and/or other Change in Condition Progress Note (if completed) N/A was checked -In the area of Advance Care Orders (POLST, MOLST, POST, Others) Send These Documents if available: Most Recent History and Physical Recent MD/NP/NP and Specialist Orders Flow Sheets (e.g. diabetic, wound care) Relevant Lab results (form the last 1-3 months) Relevant x-rays and other Diagnostic Test Results. No other documentation was provided. The MDS Coordinator stated, she did not have any other documentation. 12VAC5-371-150 (G) Resident Rights. Based on staff interview and facility documentation, the facility staff failed to provide evidence the facility was registered to receive automatic notification from the Sex Offender Register. The findings included: An interview was conducted with the Administrator on 11/09/21 at approximately p.m., 11:30 a.m. When asked if the facility was registered to receive automatic notification from the Sex Offender Registry, he replied, "Yes, Admission registered a couple of day ago." On the same day at approximately 3:20 p.m., the Administrator presented a letter dated 11/09/21, timed at 12:57 p.m., (after the surveyors arrived on site), which read, "Thank you for registering	F 001	1.The facility Administrator has registered to receive automatic notification from the sex offender register on 11/10/21. 2.Residents who reside in the facility have potential to be affected. 3.The Administrator has been reeducated on registering to receive automatic notification from the sex offender register.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 6 for Community Notification with the Virginia State Police Sex Offender and Crimes against Minors Registry." The Administrator was asked to provide evidence that Admission signed up to receive automatic notification from the Sex Offender Registry a couple of days ago, prior to the start of this survey. The Administrator stated, I will get that information to you as soon as possible. On 11/10/21 at approximately 9:35 a.m., the Administrator stated, "I apologize, it was never done" when asked, what was never done, he replied, "Registering for the Sex Offender Registry prior to you entering the facility." The Administrator and Vice President of Operations were informed of the above finding during a debriefing on 11/10/21 at approximately 3:15 p.m. The facility staff did not present any further information about the findings. 12VAC5-371-150 (G)(H). Resident Rights. Based on staff interview and facility documentation, the facility staff failed to provide evidence prior to Resident #3's admission whether she was registered as a sex offender and failed to ensure Resident #3 was provided with information on how to assess the Sex Offender Registry and evidence that the facility obtained signed acknowledgement from Resident #3 and or Resident Representative. The findings included: Diagnosis for Resident #3 included but not limited Anxiety disorder. Resident #3's Minimum Data Set (MDS-an assessment protocol) an Admission 5-day assessment with an Assessment Reference Date (ARD) of 1/23/21 coded Resident	F 001	4.The facility Administrator will report continued receipt of receiving automatic notification from the sex offender register x 2 months to be reviewed monthly/quarterly at Qapi meeting and discrepancies to be addressed. 5.AOC date 12/15/21. 1. Resident #3 was admitted to the facility on 10/17/21 and the sex offender registry was checked on 11/11/21. 2. New residents admitted to the facility will have a sex offender registry review and a signed sex offender acknowledgement form completed. Information will be provided to residents on how to access the sex offender registry. Current residents medical records will be reviewed for completed sex	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 7 #3 a 06 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive skills. An interview was conducted with Admission on 11/10/21 at approximately 12:55 p.m., who was asked to provide evidence that the facility checked to see if Resident #3 was registered as a sex offender prior to her admission on 10/17/21 and evidence that the facility provided Resident #3 or her representative with information on how to assess the Sex Offender Registry and evidence that the facility obtained signed acknowledgement from Resident #3 or her representative. On the same day at approximately 12:55 p.m., Admission stated, "I am unable to locate evidence in the resident's medical record of the information request." The Administrator and Vice President of Operations were informed of the above finding during a debriefing on 11/10/21 at approximately 3:15 p.m. The facility staff did not present any further information about the findings. (LT) 12VAC5-371-220 (C.1). Nursing Services. Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to identify an Unstageable Pressure ulcer for one of eight residents. Resident #5 in the survey sample. The findings included: Resident #5 was originally admitted to the facility on 10/04/21 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Difficulty	F 001	offender acknowledgement form and how to access the sex offender registry website. Residents with responsible parties will be sent a certified letter explaining how to access the sex offender registry and a self-addressed envelope for signed document to be returned to the facility. The Admission Coordinator identified during survey is longer an employee of the facility 3. The Admissions Coordinator has been reeducated on the admission process of checking the sex offender registry prior to admission & upon admission the sex offender acknowledgement form will be completed which contain information on how to access the sex offender registry. An audit will be completed with each admission to verify completion of sex offender acknowledgement form and sex offender registry checked prior to admission. 4. Results of audit will be reviewed in the monthly/quarterly Qapi meeting. Any discrepancies will be addressed immediately and reeducation provided as needed. 5.AOC date 12/15/21.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 8 in Walking and Reduced Mobility. The admission, a 5 day assessment Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/04/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #5 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring limited assistance of one person with bed mobility, transfers, walking, locomotion on and off the unit, dressing and eating and personal hygiene. Requiring extensive assistance of one person with toileting. Requiring total dependence with bathing. In section "M" (Skin Conditions) M0100 Determination of Pressure Ulcer/Injury Risk: Section A reads: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. =No. Section B reads: Formal assessment instrument/tool (e.g., Braden, Norton, or other) = Yes. Section C reads: Clinical assessment= Yes. M0150 Risk of Pressure Ulcers/Injuries. Is this resident at risk of developing pressure ulcers/injuries? =Yes. M0210. Unhealed Pressure Ulcers/Injuries. Does this resident have one or more unhealed pressure ulcers/injuries? = No. Stage 2, 3 or 4 Pressure ulcer present=left blank. Number of Unstageable Pressure Ulcers upon admission=Left blank. The care plan dated 10/19/21 reads: Focus: Pressure ulcer risk due to decreased mobility. Goal: Skin will remain intact. Interventions: Complete Braden Scale per Living Center Policy, Conduct weekly skin inspection, Do not massage over bony prominence, Nutritional and Hydration	F 001	1. Resident #5 continues to be seen by wound physician weekly. Weekly skin assessment have not identified any new pressure areas. 2. Residents who reside in the facility have the potential to be affected. New admission will have a skin assessment completed by licensed nurse. 3. Licensed nursing staff will be reeducated on skin observations & documentation of pressure ulcers of new admissions. Unit manager/Designee will perform complete body assessment after admission nurse within 24 hours. Director of Nursing will audit new admission skin assessment documentation weekly x3 months. 4. Results of audit will be reviewed in the monthly/quarterly Qapi meeting. Any discrepancies will be addressed immediately and reeducation provided as needed. 5.AOC date 12/15/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 9 support, Referral to Therapy, Skin assessment to be implemented per Policy, Toileting plan, Treatments as ordered. A review of the ED (Emergency Department) notes dated 10/01/21 reveal no skin issues. A review of the LTC (Long Term Care/Facility) History and Physical (H&P) progress notes dated 10/05/21 reveal no skin related issues. A review of the initial facility nursing progress notes from 10/05/21 until 10/28/21 reveal no skin issues except for the surgical wound on residents spine. The POS (Physicians Order Summary) for October 2021 reads: Santyl Ointment 250 unit/GM apply to coccyx topically every day shift for UTD (unable to determine) Cleanse coccyx with wound cleanser apply santyl and DSD (dry sterile dressing) daily. Order date 10/28/21 Start Date 10/29/21. Weekly skin review on Monday every day shift every Monday for skin integrity. Order date 10/05/21. Start Date 10/11/21. The POS for November 2021 reads: Santyl Ointment 250 unit/GM apply to coccyx topically every day shift for UTD (unable to determine) Cleanse coccyx with wound cleanser apply santyl and DSD (dry sterile dressing) daily. Order date 11/03/21. Start Date 11/04/21. Weekly skin review on Monday every day shift every Monday for skin integrity. Order date 10/05/21. Start Date 10/11/21.	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 10 The initial wound evaluation and management summary dated 11/02/21 reads: Resident present with incontinence associated dermatitis of unknown duration. Wound present on buttocks. Unstageable (Due to necrosis) Coccyx Full Thickness. Wound size = Length 2.0 Width = 1.1 Depth 0.1 cm (2 x 1.1 x 0.1 cm). Dressing and Treatment Plan = Primary dressing: Santyl apply once daily x 30 days. Secondary dressing: Gauze Island. Apply once daily for 30 days. Recommendations: Off-Load wound. Surgical Excisional Debridement Procedure: Remove necrotic tissue and establish the margins of a viable tissue. Procedure note: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 2.2 cm of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissues were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. The wound evaluation follow up dated 11/09/21 reads: Resident has an unstageable (due to necrosis) coccyx for at least 7 days duration. There is light serous exudate. Measurements: Length = 2.0 x Width =1.1 x Depth =0.1 cm. Wound Progress is unchanged. Dressing Treatment plan: Primary dressing: Alginate Calcium apply once daily for 30 days. Secondary dressing: gauze island dressing with border apply once daily for 23 days. Recommendations: Off-load wound.Triggering conditions: At this time Resident has a surgical wounds there is no pressure related area. Goal is to maintain skin integrity. Braden Scale dated 10/06/21 reads: Sensory	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 11 Perception: No impairment. Moisture: Skin is occasionally moist. Activity: Walks occasionally. Mobility: Slightly limited. Nutrition: Adequate. Friction and Shear: No apparent problem. Score =19. Braden Scale dated 10/13/21 reads: Unchanged. Score=20. Braden Scale dated 10/13/21 reads: Unchanged. Score = 17. Braden Scale dated 10/20/21 reads: Moisture =Very moist. Score = 19. SEVERE RISK: Total score 9 HIGH RISK: Total score 10-12. MODERATE RISK: Total score 13-14 MILD RISK: Total score 15-18. Initial Non-decubitus assessment dated 10/04/21: Description of site/location :Upper Back. Describe type of skin condition: surgical site s/p spinal surgery. Size in CM (Length x Width x Depth). 5.0x2.cm. site is well approximated and intact. Weekly Skin Checks: 10/04/21 reads: Skin clear, no change of condition assessed. 10/11/21 reads: Wound/Skin condition Present/No new change of condition. Documentation already established on all existing Wound/Skin. 10/18/21 reads: Wound/Skin condition Present/No new change of condition. 10/25/21 reads: Wound/Skin condition Present/No new change of condition. Documentation already established on all existing Wound/Skin Conditions. 11/01/21 reads: Wound/Skin condition Present/No new change of condition. Documentation already established on all existing Wound/Skin Conditions. 11/08/21 reads: Wound/Skin condition Present/No new change of condition.	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 12 Documentation already established on all existing Wound/Skin Conditions. Initial Pressure Injury Assessment: Date first observed: 10/28/21. Reads: Site=Sacrum. Type: Pressure. Length = 2.5 Width = 1 Depth. = 0.1 Stage = Unstageagle. Current Treatment and notes: Resident states "it was a scab that came off." Resident able to turn and reposition self, ambulatory with assistance. Cushion in place in wheelchair. Area present with 100% slough. NP (Nurse Practitioner) called and notified. New order initiated to cleanse with wound cleanser apply santyl and DSD (Dry Sterile Dressing) daily. RP called, voicemail left awaiting return call. Review of wound care note dated 10/28/21 reads: Sacrum - Pressure: Length = 2.5, Width = 1, Depth = 0.1, - Stage Unstageable. Drainage? Yes. minimal, amount of thin, pink drainage with no odor. No tunneling or undermining present. According to the wound care assessment dated 10/28/21 the pressure ulcer on the resident's sacrum was found at an advance stage (Unstageable). A review of the hospital admission and discharge summary reveal no Pressure ulcers. The admission assessment dated 10/04/21 at 1725 (5:25 PM) assessed resident's skin as having a neck incision. Indicating a surgical wound. On 11/09/21 at approximately 1:30 PM during the initial tour an observation was made of resident #5 sitting up in her bed. A cervical collar was intact. Resident expressed her concerns about wanting to be discharged home but needing assistance in order to go home. She also stated	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 13 that she had a scab on her bottom that came off. "The nurses are cleaning it and putting a dressing on it." Permission was granted to the surveyor from Resident #5 to observe the area on her buttock once a nurse was available. On 11/10/21 Wound care observation was conducted with the wound care nurse/LPN (Licensed Practical Nurse #5). No issues observed. The wound care nurse states the wound on the sacrum remains unchanged. On 11/10/21 at approximately 1:48 PM an interview was conducted with Licensed Practical Nurse (LPN) #2 concerning Resident #5. She stated, "The agency nurse didn't capture the scab on the residents sacrum on admission. LPN #3 noticed a scab on the resident's sacrum. We discussed it on 10/28/21 with the Nurse Practitioner. The only site that was documented on the weekly skin assessment was the surgical incision on the resident's neck. The body assessment doesn't show up in PCC (Point Click Care) so the nurse didn't know how to document the area on the sacrum. You should put a nursing note at the first identifying it. The treatment should have started once the nurse notice it earlier on. I did a verbal inservice on educating the staff. On 11/10/21 at approximately 2:30 PM, an interview was conducted with LPN #3 concerning Resident #5. She stated, "I had her two days after she was admitted here from the hospital (10/06/21). I saw a damond shaped scab on her rear when I was taking her to the bathroom. I thought that it was present on admission. There was no drop down for me to document on my skin assessment. I saw it continually when I did skin assessments. I thought that I had no reason	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 14 to address it. Moving forward I will check the initial assessment when they are aditted here. On 11/10/21 at approximately 2:40 PM., an interview was conducted with CNA (Certified Nurses Assistant) #1 concerning Resident #5. She stated, "I was working on the isolation unit when the resident first came in. I didn't see her until day 5 when I returned back to work. The area on her bottom was the size of a dime scabbed over. I told the agency nurse." On 11/10/21 at approximately 2:45 PM., an interview was conducted with the Wound Care Consultant concerning the area identified on Resident #5's sacrum. She stated, "I was only consulted eight days ago. The area is unchanged. The resident sits in her chair too long therefore putting a lot of pressure on her bottom. On 11/10/21 at approximately 3:55 PM., the above findings were discussed with Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 12VAC5-371-220 (D) (F). Quality of Care. Based on resident interview, staff interviews and clinical record review the facility staff failed to ensure 1 resident received fingernail care (Resident #3) and failed to provide personal care to include showers twice a week for 3 residents (Resident #4, Resident #2 and Resident #7) in the survey sample who was unable to independently carry out activities of daily living (ADL's). The findings included:	F 001	1.Resident #3 fingernails have been cleaned and trim. Resident #4, Resident #2 and Resident #7 continue to receive perineal hygiene care and offering of showers twice a week with documentation.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 15 1. The facility staff failed to ensure that fingernail care was provided to Resident #3. Resident #3 was admitted to the facility on 10/17/21. Diagnosis for Resident #3 included but not limited Rheumatoid Arthritis and Glaucoma. Resident #3's Minimum Data Set (MDS-an assessment protocol) an Admission 5-day assessment with an Assessment Reference Date (ARD) of 1/23/21 coded Resident #3 a 06 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive skills. The MDS under section G (functional status) coded Resident #3 total dependence of one with bathing, extensive assistance of two with bed mobility and toilet use, extensive assistance of one with transfer, dressing and personal hygiene and limited assistance of one with eating for Activities of Daily Living (ADL) care. The comprehensive care plan with a revision date of 10/07/21 documented Resident #4 with physical functioning deficit related to mobility impairment and self-care impairment. The goal set for the resident by the staff is to improve resident's current level physical functioning. One of the interventions to manage goal include to assist with personal hygiene. Resident #3's comprehensive care plan with a created date of 11/04/21 documented Resident #3 has a physical functioning deficit related to generalized weakness and anxiety. The goal set by the staff that the resident will maintain current level of physical functioning. Some of the interventions to manage goal include to assist with personal hygiene and provide nail care as	F 001	2. Residents who require assist with personal hygiene have the potential to be affected. Residents hygiene bathing preference will be care plan. 3. Nursing staff will be inserviced by Unit manager offering showers twice weekly and providing nail care as needed. Unit manager/designee will audit shower documentation weekly x3 months. 4. Results of audits will be reviewed in the monthly/quarterly Qapi meeting. Any discrepancies will be addressed immediately and reeducation provided as needed. 5. AOC date 12/15/21.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 16 needed. During the initial tour on 11/09/21 at approximately 11:47 a.m., Resident #3 was observed lying in bed with his hands placed outside of the covers. The surveyor observed Resident #3 fingernails were long with a brown substance under each fingernails. The resident said my fingernails need to be cut and cleaned because they are filthy. On 11/10/21 at approximately 11:00 a.m., Resident 3's fingernails remained unchanged. On the same day at approximately 11:07 a.m., Resident #3's fingernails were assessed with License Practical Nurse (LPN) #4. The LPN stated Resident #3's fingernails need to be cleaned, cut and trimmed. The LPN said the CNA's are responsible for maintaining fingernail care; they should be assessing the resident fingernails daily during ADL care and on their shower days. The LPN said, I'll make sure it's taken care of right away. On the same day at approximately 1:55 p.m., Resident #3's fingernails remain unchanged, long with a brown substance under each fingernails. There was no evidence in Resident #3's clinical record of a history of refusing nail care. The Administrator and Vice President of Operations were informed of the above finding during a debriefing on 11/10/21 at approximately 3:15 p.m. The facility staff did not present any further information about the findings. 2. The facility staff failed to ensure Resident #4 was offered and received a scheduled twice-weekly showers to maintain good personal	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 17 hygiene. Resident #4 was originally admitted to the facility on 12/26/18. Diagnosis for Resident #4 included but not limited to right above the knee amputation. Resident #4's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 09/30/21 coded the resident's Brief Interview for Mental Status (BIMS) score 12 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #4 requiring supervision with one assist with transfer, bed mobility and toilet use, supervision with dressing and eating for Activities of Daily Living (ADL) care. The comprehensive care plan with a revision date of 10/07/21 documented Resident #4 with physical functioning deficit related to mobility impairment and self-care impairment. The goal set for the resident by the staff is to improve resident's current level physical functioning. One of the interventions to manage goal include to assist with personal hygiene. During the initial tour on 11/09/21 at approximately 12:35 p.m., Resident #4 observed sitting up in her wheel chair fully dressed. When asked if she was receiving showers, she replied, "No." The surveyor asked, "When was the last time you received a shower" the resident stated, "I can't remember but it's been a while." The resident said my shower days are on Tuesday and Fridays, I should have gotten a shower today but it was never offered. Review of Resident #4's Order Review Summary revealed the following order: Showers every day shift on Tuesday and Friday for hygiene.	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 18 Review of Resident 4's ADL Documentation Survey Report revealed showers were not given on the following shower days: October 2021 (10/01, 10/05, 10/8, 10/12, 10/15, 10/19, 10/26 and 10/29/21). November 2021 (11/02, 11/05 and 11/09/21). The ADL Documentation Survey Report to include showers given was reviewed with the Unit Manager (UM) on 11/10/21 at approximately 11:10 a.m. The Unit Manager stated, "Apparently Resident #4 did not receive any of her showers on her scheduled shower days." The UM said if Resident #4 refused her showers, the Certified Nursing Assistant (CNA) should leave and attempted again later. She said if the resident still refuse their shower, the CNA is to report the refusal to the Charge Nurse or UM. The UM or Charge Nurse will speak with the resident and if the resident still refuses, the refusal is documented in the resident's clinical record. The Administrator and Vice President of Operations were informed of the above finding during a debriefing on 11/10/21 at approximately 3:15 p.m. The facility staff did not present any further information about the findings. 3. The facility staff failed to ensure Resident #2 was provided with showers two times a week. Resident #2 was readmitted to the facility on 10/05/21 with diagnoses which included depression, anxiety, restlessness, agitations, paranoid schizophrenia and intellectual disability. Resident #2 had a physician's order dated 10/07/21 for showers Q (every) Monday and Friday during 7-3 P.M. shift for hygiene. A review	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 19 of the Care Plan dated 10/21/21 did not include interventions for showers or bed baths. A review of the Activities of Daily Living forms for the months of October and November 2021 did not indicate Resident #2 had been provided with showers. During an interview at 10:21 a.m. on 11/10/21 with the Unit 1 Manager, she stated, "We are not able to provide Resident #2 with showers because of her refusal and behaviors." A facility shower policy was requested from the Director of Nursing but not provided. 4. Based on a medical record review, a resident interview and staff interviews the facility staff failed to offer Resident #7 a shower twice a week since admission. Resident # 7 was admitted to the facility on 9/9/21 with diagnoses to include but no limited to Heart Failure, Kidney Disease and Diabetes Mellitus. The most recent comprehensive Minimum Data Set (MDS) was a significant change with an Assessment Reference Reference Date (ARD) of 9/15/21. Resident #7's Brief Interview for Mental Status (BIMS) was coded as a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section G Functional Status G0120. Bathing, Resident #7 was coded as requiring one person physical assist for bathing activity. On 11/9/21 at 1:00 p.m. an interview was conducted with Resident #7 in her room. Resident #7 was asked if she was being offered showers twice a week by the facility staff.	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 20 Resident #7 stated, "Showers, I haven't had a shower since I got here in September. All I get is a bath bed bath, I would love a shower." The facility shower schedule for Unit 2 where Resident #7 resides was reviewed and is documented in part, as follows: Monday/Friday 3-11 Rooms 38-1 and 38-2. Resident #7's physician orders were reviewed and are documented in part, as follows: SHOWER DAYS: Monday and Friday on 3 to 11 shift. Order Date: 9/29/21. Resident #7's Activity of Daily Living (ADL) documentation for Bathing from 10/12/21 through 11/9/21 was reviewed. Resident #7 was coded as having a Bed/Towel Bath for all 15 entries. The shower column and the resident refusal column had zero entries from 10/12/21 through 11/9/21. Attempted to contact the 3-11 Certified Nursing Assistants responsible for Resident #7's showers, however all were agency staff and no calls were returned. On 11/10/21 at 1:45 p.m. an interview was conducted with the Director of Nursing regarding Resident #7 not receiving any showers since her admission and what were his expectations of the staff regarding showers. The Director of Nursing stated, "I expect that everyone gets showers as they like them and if they don't want one we have to honor that. I expect the CNA's (Certified Nursing Assistants), to offer showers twice a week to their residents and document any refusals."	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 21 On 11/10/21 at approximately 2:20 p.m. a pre-exit debriefing was conducted with the Administrator and the Vice President of Operations were the above findings were shared. No further information was provided prior to exit. 12 VAC 5 -371-250 (I) Resident Assessment and Care Planning Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to invite 3 of 8 residents (Resident #6, Resident #1 and Resident #2) to attend care plan meetings in the survey sample. The findings included: 1. Resident #6 was originally admitted to the facility on 01/30/2020 and has never been discharged from the facility. The current diagnoses included; Schizophrenia and Major Depressive Disorder. A quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/09/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #6 cognitive abilities for daily decision making were moderately impaired. In section "G"(Physical functioning) the resident was coded as requiring supervision with set-up help only with bed mobility and transfers, dressing and eating. Independence with locomotion on the unit and supervision with locomotion off the unit. Requiring supervision of one person with toilet use, personal hygiene and bathing.	F 001	1. Resident #6, Resident #1 and Resident #2 or power of attorney (POA) will be provided a care plan invite to attend the care plan meetings according to RAI manual. Resident # 6 had care plan meeting held on 11-23-21 with resident's POA participating via phone.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 22 On 11/09/21 at approximately 1:15 PM during the initial tour Resident #6 was observed sitting in his room watching TV. He was asked if he was invited to quarterly care plan meetings. He stated, "No." On 11/10/21 at approximately 9:05 AM., an interview was conducted with Resident #6 concerning care plan meetings. He stated," "I will attend the meetings if they invite me to them." On 11/10/21 at approximately 10:10 AM., an interview was conducted with the Social Services worker (OSM/Other Staff Member #6) concerning Resident #6 attending Care Plan meetings. She stated, "The resident refuses to go to Care Plan meetings. He should have had Care Plan meetings in February and May. I have this invite letter from August meeting but he refused to attend the meeting. It's not documented in the clinical record (Resident's refusal). On 11/10/21 at approximately 2:40 PM., a meeting was conducted with the Social Services worker concerning Resident #6. She stated, "The family is not active in visiting the resident and they don't participate in the care plan meetings. The meeting dates were on 2/22/21, 5/24/21 and 8/16/21. I can't locate the notes. I will send out care plan meeting invites to the families moving forward." A review of the clinical record was conducted no record of care plan meetings were noted in the clinical chart. On 11/10/21 at approximately 3:55 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate	F 001	2. Residents who reside in the facility have the potential to be affected. Residents / POA will be provided with an invite to participate in care plan meeting according to the RAI manual. 3. The facility Social Services Worker has been re-educated on providing care plan invite letters to residents /POA of care plan meetings and documentation of meetings. The Social Services Worker will complete a weekly audit tool x2 months of scheduled care plan meetings and	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 23 Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. On 11/10/21 at approximately 3:55 PM., the above findings were discussed with Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. On 11/10/21 at approximately 4:15 PM surveyor was approached by the Social Services Worker. She stated, "I couldn't find any invite letters on Resident #6. I will make sure to talk to the resident and call family members and to document resident refusals. No policies are available." 2. The facility staff failed to provide a meaningful opportunity for Resident #1 to participate in his Care Plan meetings. Resident #1 was readmitted to the facility on 04/08/21 with diagnoses which included CVA, left side hemiparesis, kidney failure, CHF, gangrene of right foot, and hypertension. Resident #1 was assessed as a 12 on the Brief Interview of Mental Status (BIMS) dated 8/26/21. A review of the clinical records indicated Resident #1 had a significant change MDS 05/28/21. A review of the clinical records did not indicate, Resident #1 was invited or had the opportunity to participate in his Care Plan meeting. The Social Service Director stated, she was not employed at the facility at the time. 3. The facility staff failed to provide a meaningful	F 001	invite letters with documentation of attendance. 4. Results of the audit will be reviewed at the monthly/ quarterly QAPI meeting. Any discrepancies will be immediately addressed and re-education provided as needed. 5. AOC 12-15-21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 24 opportunity for Resident #2 to participate in her Care Plan meetings. Resident #2 was readmitted to the facility on 10/05/21 with diagnoses which included depression, anxiety, restlessness, agitations, paranoid schizophrenia and intellectual disability. Resident #2 had not received a Care Plan notification since March 2, 2021. Resident #2's sister was her authorized Representative. She stated during an phone interview at 3:15 p.m. on 11/10/21 that she had not received a care plan meeting notification for her sister in months. The Social Service Director provided a care plan meeting notice dated March 2, 2021 for a scheduled March 11, 2021 Care Plan meeting. The Social Service Director stated she was not employed at the facility during this time. An email dated 10/07/21 was provided by the Social Service Director on 11/10/21 which indicated the following from Minimum Data Set (MDS) staff: "Please add the following to your care plan list for 10/07/21." The Social Service Director was asked how Resident #2's representative would have an opportunity to participate in Resident #2's Care Plan meeting and she stated, we would call her on the day of the meeting. (AD, WC) 12VAC5-371-300 (D, H). Pharmaceutical services. Based on observation, clinical record review, staff interview the facility, the failed to ensure 2 out of 8 Residents (#4 and Resident #2) in the survey sample was seen by the pharmacist for Medication Regimen Review on a monthly basis	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 25 and failed to ensure Resident #2 did not receive unnecessary psychotropic medications. The findings included: (AD) 1. The failed to ensure Residents #4 was seen by the pharmacist for Medication Regimen Review (MRR) on a monthly basis. Resident #4 was originally admitted to the facility on 12/26/18. Diagnosis for Resident #4 included but not limited to Major Depression Disorder. Resident #4's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 09/30/21 coded the resident's Brief Interview for Mental Status (BIMS) score 12 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #4 requiring supervision with one assist with transfer, bed mobility and toilet use, supervision with dressing and eating for Activities of Daily Living (ADL) care. Resident #4 comprehensive care plan documented Resident #4 with potential for drug related complications associated with the use of psychotropic medication for anti-depressant medication. The goal set for the resident by the staff is to be free of psychotropic drug related complications. One of the intervention/approaches to manage goal included to have monthly pharmacy review of medication regimen. Review of the clinical record review revealed no Medication Regimen Review notes for 04/21 and 06/21.	F 001	1.Resident #4 medical record was reviewed by a consultant pharmacist on 10/19/21 and 11/21/21 with no recommendations or irregularities noted. Resident #2 has had a consultant pharmacist review on 10/20/21 and 11/21/21. Resident #2 current medication ordered have been reviewed by attending physician and orders addressed as prescribed. Resident #2 Attivan prn medication order was discontinued on 11/26/21.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 26 An interview was conducted with Director of Nursing (DON) on 11/10/21 at approximately 2:55 p.m. who stated, "The pharmacist should see all residents on a monthly basis." The Administrator and Vice President of Operations were informed of the above finding during a debriefing on 11/10/21 at approximately 3:15 p.m. The facility staff did not present any further information about the findings. The facility's policy titled Medication Monitoring - Medication Regimen Review and Reporting 8.1 (Revision - 2007). -Policy: Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identity, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the IDT, including the resident, their family and/or resident representative. -Procedures read in part... 2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Definitions: Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect	F 001	2.Residents in the facility with physician orders for medications have had a consultant pharmacist review their medication regimen for the month of November. A consultant pharmacist will review the medication regimen of residents in the facility monthly in accordance with State regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 27 how you feel, think, and handle daily activities, such as sleeping, eating, or working. (WC) 2. The facility staff failed to ensure Resident #2 did not receive unnecessary psychotropic medication. Resident #2 was readmitted to the facility on 10/05/21 with diagnoses which included depression, anxiety, restlessness, agitations, paranoid schizophrenia and intellectual disability. Resident #2 had a signed physician order dated 09/08/21 for Ativan Tablet 1 (MG) milligram give 1 tablet by mouth every 8 hours as needed for combativeness/agitation. A Medication Administration Record (MAR) dated September 2021 indicated as needed (PRN) Ativan 1 mg tablet were administered on the following dates and times: September 1, 2021 at 1938 (7:38 p.m.), September 2, 2021 at 1148 (11:48 a.m.), and 2016 (8:16 p.m.), September 3, 1851 (6:51 p.m.), September 7, 2021 0408 (4:08 a.m.), September 8, 2021 1103 (11:03 a.m.), September 9, 2021 0900 (9:00 a.m.) and 1800 (6:00 p.m.), September 10, 2021 1225 (12:25 p.m.), September 11, 2021 0432 (4:32 a.m.), September 12, 2021 0912 (9:12 a.m.), September 16, 2021 0755 (7:55 a.m.), September 17, 2021 1700 (5:00 p.m.), September 19, 2021 (0839) 8:39 a.m.), September 21, 2021 2030 (8:30 p.m.), September 22, 2021 1701 (5:01 p.m.), September 23, 2021 0627 (6:27 a.m.), September 25, 2021 0105 (1:05 a.m.), September 26, 2021 0912 (9:12 a.m.), and September 30, 2021 0337 (3:37 a.m.). Resident #2 had a signed physician order dated	F 001	3. The Director of Nursing has been re-educated by the Regional Clinical Director on monitoring the consultant pharmacist review of resident's medication regimen and documenting monthly recommendations or irregularities. 4.Results of audits will be reviewed in the monthly/quarterly QAPI meeting. Any discrepancies will be addressed immediately and or re –education provided as needed. 5. AOC date 12-15-21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 28 10/01/21 for Ativan Tablet 1 MG give 1 tablet by mouth every 8 hours as needed for combativeness/agitation. A Medication Administration Record (MAR) dated October 2021 indicated as needed (PRN) Ativan 1 mg tablet were administered on the following dates and times: October 2, 2021 0839 (8:39 a.m.), October 3, 2021 0827 (8:27 a.m.), October 5, 2021 0017 (12:17 a.m.), October 16, 2021 0438 (4:38 a.m.) and 1400 (2:00 p.m.), October 18, 2021 2053 (8:53 p.m.), October 24, 2021 1708 (5:08 p.m.), October 25, 2021 0130 (1:30 a.m.), October 26, 2021 0130 (1:30 a.m.), October 27, 2021 0511 (5:11 a.m.), October 28, 2021 0533 (5:33 a.m.), and October 29, 2021 0606 (6:06 a.m.). During an interview on 11/09/21 at 3:30 p.m. with the Unit 1 Manager, she stated, Resident #2's physician and the pharmacist were aware of her medications and scheduled doses. The facility did not provide a policy and procedure upon request for unnecessary medications. (SR) 12VAC5-371-340 (D.-B&C). Based on observations, staff interviews and facility document review the facility staff failed to store and prepare food in a safe and sanitary manner. On 11/9/21 at 3:20 p.m. a kitchen inspection was completed. While inspecting the dry storage room an open 50 pound bag of all purpose flour was observed on a lower shelf. The current Dietary Manager walked into the room and was made aware of the open bag. The Dietary Manager stated, "Wow, was it like that. After it is	F 001	1. The bag of all purpose flour identified during the survey has been replaced. The current bag of flour is stored in a sealed container with date of opening affixed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 29 opened it should be stored in a sealed container or at least the bag should have been sealed and dated." On 11/9/21 at 4:07 p.m. while entering the kitchen to observe the dinner tray line the following observations were made. Two staff members a Dietary Manager helping from a sister facility and the Dietary Aide were observed prepping salads for the dinner meal. The Dietary Manager was observed with his bare hands in a bag of lettuce and placing the lettuce with his bare hands into the resident salad bowls. The Dietary Aide was observed with her bare hands inside a clear container of chopped tomatoes and placing the chopped tomatoes with her bare hands into the resident salad bowls. When both staff members looked up and saw this surveyor they immediately stopped filling the resident salad bowls and backed away from the table removing their bare hands form the lettuce and the chopped tomatoes. There were sixteen filled resident salad bowls on the table that the two staff members were prepping with their bare hands. All sixteen salad bowls were thrown into the trash by the Dietary Aide. The Dietary Manager and the Dietary Aide were asked why they were prepping the resident salads with their bare hands and no gloves. The Dietary Aide stated, "I'm new, it's my first day and he (Dietary Manager) was just trying to help speed things up. I should have stopped and put my gloves on." The Dietary Manager from the sister facility stated, "Well we were running behind. I had to run out and get the lettuce and we were rushing to finish the salads. I was helping was helping because it's the Dietary Aide's first day and the Dietary Manager is also new. We should have had our gloves on, because we are dealing with a vulnerable population that can easily become sick if we don't	F 001	The Dietary Manager who providing assistance to facility dietary staff has not been at facility since 11- 9-21. The new dietary aide identified as not wearing gloves during food preparation voluntarily resigned on 11/09/21. The facility Business Office Manager has received education on proper attire to wear when entering the kitchen on 11/12/21.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 30 handle and prepare the foods properly. The Dietary Manager and the Dietary Aide were asked if they would eat food that someone's bare hands had been in. Both kitchen staff members stated, "No." On 11/9/21 at 4:20 p.m. the current Dietary Manager was made aware of the above observations with the salad prep. The Dietary Manager stated, "Are you serious, no they didn't. It is the Dietary Aides first day but everyone should know we always wash hands and wear gloves with any food handling. The Other Dietary Manager knows he should have had gloves on." On 11/9/21 at 4:16 p.m. the Business Office Manager was observed entering the kitchen, walking passed the prep table with prepared food on them and into the Dietary Managers office with no hairnet in place. The Business Office Manager was asked why she didn't put a hairnet on when she entered the kitchen. The Business Office Manager stated, "No one ever told me I should have one on. I will put one on from now on." The Dietary Manager stated, "Everyone that enters the kitchen must have a hairnet on." The facility policy titled "Food Storage: Dry Goods" revised 9/2017 was reviewed and is documented in part, as follows: Policy Statement: All dry goods will be appropriately stored in accordance with the FDA (Food and Drug Administration) food code. Procedures: 5. All packaged and canned food items will be kept clean, dry, and properly sealed. The facility policy titled "Food: Preparation" revised 9/2017 was reviewed and is documented	F 001	2. Residents in the facility have the potential to be affected. District Dietary Manager has completed a food service preparation and sanitation review of facility dietary staff meal preparation. Areas needing improvement have been addressed. 3. Facility dietary staff have received re-education on food preparation and storage to include the use of gloves on 11/12/21 by the District Dietary Manager. A new call bell has been placed outside kitchen door for facility staff to request assistance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 001	Continued From page 31 in part, as follows: Policy Statement: All dry goods will be appropriately stored in accordance with the FDA (Food and Drug Administration) food code. Procedures: 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. On 11/10/21 at approximately 2:20 p.m. a pre-exit debriefing was conducted with the Administrator and the Vice President of Operations were the above findings were shared. The Administrator was asked what are his expectations regarding safe food handling and sanitary kitchen practices. The Administrator stated, "I expect full compliance under the regulatory code. The staff should have gloves on while handling food and hairnets are to be worn by everyone who enters the kitchen." No further information was provided prior to exit.	F 001	from kitchen staff. In the event, staff must enter the kitchen hairnets have been placed outside the entrance door of kitchen. A food preparation and sanitation audit will be conducted weekly x2 months by Kitchen Manager. 4. Results of the audits will be reviewed in monthly /quarterly QAPI meeting. Any discrepancies will be addressed immediately and re-education provided as needed. 5. AOC date 12-15-21	