STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495397	A. BUILDING _____ B. WING _____	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHESAPEAKE	955 HARPERSVILLE RD NEWPORT NEWS, VA 23601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/04/22 through 1/06/22. Corrections are not required for compliance with 42 CFR Part 483.73, Requirements for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/04/22 through 1/06/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 1 complaint was investigated during the survey. The census in this 52 certified bed facility was 48 at the time of the survey. The survey sample consisted of 22 current Resident record reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		2/4/22

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

Electronically Signed | 01/31/2022

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F 578	Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation review, the facility staff failed to ensure 1 of 25 residents (Resident #46) in the survey sample was given the opportunity to formulate an Advance Directive. The findings included: Resident #46 was admitted to the nursing facility on 11/04/20. Diagnosis for Resident #46 included but not limited to Cerebral Infarction (stroke) and	F 578	1. Advance Directive (AD) was obtained for resident #46 by the social worker during survey on 1/6/22. 100% audit completed by social worker on January 6, 2022 of all resident records for presence of advance directives and no additional resident records were missing advance directives. The identified resident was not found to be affected by the deficient practice.	

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F 578	Continued From page 2 Chronic Atrial Fibrillation. Resident #46's Minimum Data Set (MDS-an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 12/27/21 coded a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. Review of Resident #46's Physician Order Sheet (POS) for January 2022 revealed the following order: Do Not Resuscitate (DNR) starting on 11/04/20. The review of Resident #46's clinical record did not show evidence of an Advance Directive. On 01/06/22 at approximately 1:47 p.m., an interview was conducted with the Social Worker, who stated, "The process for obtaining the resident's Advance Directive is discuss during the admission process." He stated, "Somehow getting the information related to Resident #46's Advance Directive was just overlooked." A debriefing was conducted with the Administrator, Director of Nursing (DON) and Staff Development Coordinator/Quality Assurance on 01/06/22 at approximately 6:38 p.m. The facility did not present any further information about the findings. The facility's policy titled Advance Directives with a review/revised date (01/10/17) included but not limited to: Policy: The resident has the right to request, refuse, and/or discontinue treatment to participate	F 578	2.Any new admission to the HC neighborhood has the potential to be affected. 3.All new admissions will be visited and evaluated by Social Services upon admission to identify the need for advanced directives. If no advanced directive is identified, the resident and/or resident representative will be provided education regarding advanced directives on the initial care plan. SW will follow up with residents identified without AD to verify decisions regarding completion of AD at the admission care plan. At each successive care plan meeting AD will be reviewed by the interdisciplinary care team. 4.All new admissions will be audited by the Director of Social Services or designee for Advanced Directives weekly for 6 weeks and quarterly thereafter. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for continued review and oversight. 5. 2/4/22 and ongoing	

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F 578	Continued From page 3 in or refuse to participate in experimental research, and to formulate an advanced directive. -Prior to or upon admission to a license area or program of the (name of facility), the resident shall be provided orally and in writing, information concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directive by the social worker or designee. Definitions: -Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm (www.Nhlbl.nih.gov).	F 578		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, it was determined that the facility staff failed to notify a state agency of misappropriation of stolen property in a timely manner for one of 25 residents in the survey sample, Resident #4. The findings include:	F 602	1.Correction is not applicable. 2.All residents with missing property have the potential for untimely notifications of incidents to state agencies. 3.The Nursing team will be re-educated by the DON or designee on notifying the	2/4/22

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F 602	Continued From page 4 Resident #4 was originally admitted to the nursing facility on 02/09/2017. Diagnosis for Resident #4 included but not limited to Muscle Weakness and Type 2 Diabetes Mellitus. Resident #4's Minimum Data Set an Annual assessment with an Assessment Reference Date (ARD) of 10/11/21 coded Resident #4 a 9 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS),This indicated Resident #4 cognitive abilities for daily decision making were moderately impaired. The facility staff failed to provide personal care to include showers for Resident #4 in the survey sample who was unable to independently carry out Activities of Daily Living (ADL's). In addition, the MDS coded Resident #4 requiring physical help of one person with bathing. Requiring extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. The care plan dated 2/09/17 reads: Resident requires assistance with ADL's (Activities of Daily Living) related to increased weakness, increased falls, decreased mobility. Increased discomfort, and impaired gait. Resident will receive assistance with all ADL's as evidenced by good grooming, neat and clean appearance, and be free of body odors daily through next review. Intervention: Bathing: Shower/bed bath. Staff to complete bathing care as needed. Resident requires: Minimum assistance with one person assistance. The FRI (Facility Reported Incident) Initial Report Date: 10/15/21. Incident Date: 10/11/21. Notification to Responsible Party: 10/11/21. Notification to Physician: 10/11/21. Notification to Law Enforcement: 10/15/21. Notification to Office	F 602	on-call Nurse immediately when there is an allegation of missing property. The On-Call nurse will notify the DON/ADON of an incident. A FRI will be submitted by the DON or designee within two hours per regulation. A Copy of faxed confirmation will be retained. Nursing staff will be educated by the DON or designee of the current policy on notifications. 4.FRIs related to misappropriation of property will be audited for timely notification to the state agency weekly x 4 and monthly x 3 by Administrator or designee. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for continued review and oversight. 5. Completion: 2/4/22 and ongoing	

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F 602	Continued From page 5	F 602		

of Licensure and Certification (OLC): 10/19/21. Incident Type: Resident Property. Incident description reads: On the evening of 10/11/21, CNA (Certified Nursing Assistant) notified supervisor of resident missing engagement ring. Resident usually has engagement ring on chain that is gold in color around. Investigation initiated and ongoing. Resident representative notified. Medical provider notified. Police report submitted. Employee Action Taken: See Final Investigation.

A review of the final investigation reveal that Resident's routine caregiver notified the evening supervisor that she found the resident's necklace on the nightstand and the diamond ring was missing. Investigations were initiated. The resident stated that "the girl came in and took off my necklace, left and then came back. She could not recall the day, time or name of the individual. She was unable to provide a description. The resident's representative, Medical Director and a police report was filed as well as resident's room was searched.

Review of the facility FRI's (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) in a timely manner. (According to the documentation the incident occurred on 10/11/21 (Monday), but was reported to VDH/OLC on 10/19/21 (Tuesday) (Excluding Saturday and Sunday) was six days reporting to VDH/OLC.)

On 01/05/22 at 2:09 PM, during the initial tour an interview was conducted with Resident #4. She was asked if she had any missing property. She stated, "Someone stole my diamond ring a few months ago."

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F 602	Continued From page 6	F 602		

On 1/06/22 at approximately 11:00 AM., an interview was conducted with the DON (Director of Nursing) concerning missing property for Resident #4. She confirmed that resident #4 reported that she was missing jewelry and an investigation was made.

On 1/06/22 an interview was conducted with the Administrator at approximately 6:30 PM., concerning Resident #4's FRI/Facility Reported Incident. She stated that an investigation was made as well as a police report filed. The case is still ongoing pending the police report. When asked if she notified OLC within the required 5 days of reporting the incident she stated, "I forwarded the incident to Virginia Department of Health on 10/19/21."

On 1/06/22 an interview was conducted with Resident's niece at 5:25 PM., concerning the incident above. She stated, " My aunt had her 3 carat wedding ring stolen. She had the ring for over forty-five years. She started wearing her ring and her late husband's ring around her neck for a few years because her ring had gotten too big on her fingers. RN (Registered Nurse) #1, said that a CNA (Certified Nursing Assistant) said that she saw the necklace on the night stand. A report was filled out by RN #1. I called the administrator and she stated that she was never told about the incident. I called the police detective and they never called me back. The administrator said that she will talk to the workers concerning the stolen ring.

Received a copy of Handbook for the Health Care Center from the administrator on 1/06/22: Highlighted in the Handbook was the Lost and Found section. It reads: The Chesapeake is not

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F 602	Continued From page 7 responsible for replacing lost or misplaced items by Resident to include dentures, hearings aids and other valuables. Residents are asked to maintain valuables off site and to lock money in the secure box in their accommodation. A review of the abuse training documents show that in-services were conducted with staff members on 10/20/21 concerning Misappropriation of Property. The Policy: Abuse dated: 5/21/21 Reads: Misappropriation: Of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Investigation: The designated staff will immediately review and investigate all allegations or observations of abuse. The result of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with state law, including to the State Survey Agency, within 5 working days of the incident and if the allege violation is verified appropriate correction action must be taken. A pre-exit interview was conducted on 1/06/2022 at approximately 6:40 PM. The above findings were shared with the Administrator, Director of Nursing and Licensed Practical Nurse of Staff Development and Quality Assurance. No concerns were voiced at this time.	F 602		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-	F 622		2/7/22

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F 622	Continued From page 8	F 622		

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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F 622	Continued From page 9	F 622		

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a

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F 622	Continued From page 10 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to send a copy of one resident's care plan (Resident #23) after being transferred to the hospital for 1 of 25 residents in the survey sample. The findings included: The facility staff failed to send Resident #23's care plan to include their goals when discharged and admitted to the hospital on 11/16/21. Resident #23 was originally admitted to the nursing facility on 10/02/19 and readmitted to the facility on 11/17/21. Diagnosis for Resident #23 included but not limited to Cognitive Communication Deficit. Resident #23's Minimum Data Set (MDS-an assessment protocol) an admission assessment with an Assessment Reference Date (ARD) of 11/23/21 coded a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. Review of Resident #23's admission MDS assessment with an ARD of 11/23/21, under Section G (Functional Status) was coded requiring extensive assistance of two with transfer and bed mobility, extensive assistance of one with dressing, hygiene and toilet use, limited assistance of one with bathing and supervision	F 622	1.Correction not applicable. 2.Any resident from Health Care who discharges (planned or unplanned) has the potential to have the care plan omitted from their discharge packet. 3. The Nursing team will be re-educated by ADON on February 4, 2022 on the regulation for transfer and discharge requirements for planned and unplanned transfers. An audit of discharged residents will be conducted upon resident's discharge by the ADON or designee, to ensure care plan is sent to accepting entity. Nursing team will continue current transfer/discharge process of ensuring appropriate documentation is sent to accepting entity. A discharge Document Checklist was revised and will be implemented on February 4, 2022 by the ADON to include planned discharges. 4. All planned discharges will have their records audited weekly by the ADON for 3 months to ensure proper documentation was sent to receiving facility. Results of all audits will be reviewed and reported at the next QAPI meeting for continued review and oversight.	

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F 622	Continued From page 11 with one assist with eating for Activities of Daily Living (ADL) care. The Discharge MDS assessments was dated for 11/16/21 - discharge return anticipated. Resident #23 was re-admitted to the nursing facility on 11/17/21. Review of Resident #23's clinical record revealed the following documentation entered on 11/16/21 at approximately 10:05 p.m., "Resident #23 will be leaving for his surgery later this morning and will return to the facility until able to secure a safe discharge plan. He did not note any negative moods but acknowledged he is moving more slowly due to the right shoulder fracture." The clinical note did not provide evidence that the resident's care plan was sent when discharged to the hospital on 11/16/21. An interview was conducted with the Administrator on 01/05/22 at approximately 1:01 p.m., who stated, "We were not able to find documentation in Resident #23's clinical record that the care plan was sent with him when discharged and admitted to the hospital on 11/16/21." A debriefing was conducted with the Administrator, Director of Nursing (DON) and Staff Development Coordinator/Quality Assurance (QA) on 01/06/22 at approximately 6:38 p.m. The Director of Nursing stated, "The purpose of sending the resident's care plan when a resident is being discharged and admitted to the hospital is to continue with their plan of care."	F 622	5. Completion Date: 2/7/22 and ongoing.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		2/4/22

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F 641	Continued From page 12 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure that 1 of 25 residents (Resident #30) in the survey sample received a complete and accurate assessment Minimum Data Set (MDS). The findings included: The facility staff failed to ensure the significant change MDS with an Assessment Reference Date (ARD) of 12/02/21 under Section M (skin conditions) for the number of stage III pressure ulcers that were present upon admission/reentry into the facility was accurate for Resident #30. Resident #30 was originally admitted to the nursing facility on 03/07/04 with a readmission date of 07/04/14. Diagnosis for Resident #30 included but not limited to stage III pressure ulcer of the sacral region. Resident #30's Minimum Data Set (MDS-an assessment protocol) significant change MDS with an ARD of 12/02/21 coded a 08 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The comprehensive care plan with a revision date of 11/29/21documented Resident #30 has a stage three sacral pressure. The goal set for the resident by the staff is there will have no further open areas caused by pressure or friction. Some of the interventions to manage goal include turn every 2 hours, prompt incontinence care,	F 641	1. The MDS code was corrected during survey by the MDS Coordinator. 100% Audit of all residents with wounds since June 2021 was completed by the MDS coordinator on January 6, 2022. No other resident records were found to have incorrect coding related to wounds. 2. Any resident with a wound who is readmitted to HC has the potential for a coding error. 3. The MDS Coordinator was re-educated on Section M using AANAC website. Risk Meetings were revised by CWCA, DON, MDS and ADMIN to specifically address residents readmitted with wounds to ensure accurate coding. The MDS Checklist was revised and implemented by the MDS Coordinator on 1/11/22 to include last MDS for wound/staging to check accuracy. 4. Residents with pressure areas that have been discharged and are re-admitted to the community will have admission MDS monitored for accuracy in Section M for 3 months by the ADON or designee. The results of all audits will be reviewed and reported at the next QAPI meeting for continued review and oversight..	

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F 641	Continued From page 13 encourage resident to allow staff to turn and reposition with the use of pillows and/or wedge, air pro mattress to bed; check placement and function every shift (effective 11/13/19). Review of Resident #30's skin evaluation form dated 11/22/21 revealed the following: facility acquired open area with darker area presented with 95% granulation tissue and 5% slough measuring 1 cm x 1 cm with light serous drainage. Review of Resident #30's significant change MDS with an ARD date of 12/02/21 was coded under section M (skin conditions) the resident presented with a stage III pressure ulcer when admitted/reentry into the facility. An interview was conducted with MDS Coordinator on 01/05/22 @ 12:35 p.m. The MDS Coordinator was asked to review Resident #30's significant change MDS with an ARD date of 12/02/21 for the accuracy of section M (skin conditions) for being admitted with a stage III sacral pressure ulcer or if the pressure ulcer was facility acquired. On the same day at approximately 2:15 p.m., the MDS Coordinator stated, "The MDS is not accurate, the resident's stage III pressure ulcer was facility acquired." A debriefing was conducted with the Administrator, Director of Nursing (DON) and Staff Development Coordinator/Quality Assurance (QA) on 01/06/22 at approximately 6:38 p.m. The facility did not present any further information about the findings. CMS's RAI Version 3.0 Manual - Chapter 1: Resident assessment Instrument (RAI).	F 641	5. Completion Date: 2/4/22 and ongoing	

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F 641	Continued From page 14 -An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff	F 686	1. Resident #15's current plan of care is	2/11/22

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F 686	Continued From page 15 interviews, and clinical record review, the facility staff failed to ensure the most appropriate pressure reducing bed surface was afforded to a vulnerable immobile resident with a history of Moisture Associated Skin Damage (MASD) to avoid further progression of the area to a stage III pressure ulcer and deterioration to a stage IV for 1 of 25 residents (Resident #15), in the survey sample. The findings included: Resident #15 was originally admitted to the facility 9/10/20, was discharged from the facility 9/23/20, return anticipated and returned to the facility 9/26/20. Resident #15's diagnoses included; recent stroke on 9/6/20 with hemiparesis (inability to move on one side) and aphasia (speech/communication problems), diabetes and dementia. The quarterly Minimum Data Set (MD'S) assessment with an assessment reference date (AR) of 12/17/20 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short-term memory problems as well as severely impaired daily decision-making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with transfers, extensive assistance of one person with bed mobility, eating, personal hygiene, bathing, dressing, and tilting. In section "H" (Bladder and Bowel), the resident was coded as incontinent of bladder and continent of bowel. Section "M" of the MDS	F 686	up to date with most current treatment and interventions to promote wound healing. 2.All residents are at risk and could be affected. A 100% audit will be conducted by DON and Staff Development Coordinator of the Braden Scale scores to ensure that appropriate preventative measures are in place for each resident. 3.Nursing Team members will be re-educated on the causes of MASD, interventions to use to prevent skin breakdown, use of the Braden Scale and how to interpret, how incontinence/moisture affects skin, and the importance of nutrition. The skin protocol policy will be revised to include the following: a. All residents that develop MASD will be placed on an appropriate bed surface. b. An order will be obtained by the nurse for the appropriate bed surface at the time of application. c. The care plan will be updated to reflect the change in plan of care. d. All residents who are incontinent will receive preventative skin care to include moisture barrier to be applied after each incontinent episode. e. A Braden assessment will be completed with each newly identified skin injury. f. Residents with newly identified skin injury will be assessed for appropriate treatment modalities. g. Residents with newly identified skin	

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F 686	Continued From page 16 assessment revealed the resident had a potential for skin breakdown but the assessment was coded for no skin impairments. The 10/19/20 the Braden scale for predicting pressure sore risk score was 13. The tool stated if the Resident's score was 12 or less; consider the resident at risk for pressure ulcer development. (The 1/2021 Braden assessment was omitted). The next Braden scale predictor was completed 3/23/21. The score was 14. The Braden assessment revealed the resident was with very limited ability to respond meaningfully to pressure related discomfort, the residents skin is often to exposed to moisture, the resident is bedfast, has very limited ability to control and change body position, rarely eats a complete meal, requires moderate to maximum assistance with moving to prevent skin friction and shearing. A care plan problem dated 9/26/20 read actual skin breakdown related to delicate skin, immobility, hemiparesis, diabetes, incontinence, behaviors with refusal of care and history of skin breakdown (There is no indication what the problem was at that time for there were no treatment for this actual skin breakdown). The goal read; Resident will have no further open areas caused by pressure of friction through the next review. The interventions included; skin risk assessment; Braden scale upon admission, significant change, quarterly and as needed. The interventions included; pressure relieving device in wheel chair. Pressure relief mattress to bed. Lotion skin with care, avoid friction over bony prominences. Check care during ADL care daily. Protective skin barrier after incontinence. Diabetic shoes. Check every two hours for incontinence and change as indicated.	F 686	injury will be added to weekly wound rounds by the DON and Wound nurse and followed until resolved. h. Registered Dietitian will be consulted as indicated. i. Resident's Representative will be notified and educated on skin injury and surface changes. j. The plan of care will be updated and reflect resident specific interventions based on the Braden Scale results. 4. Interdisciplinary notes (IDN) and Incident reports will be reviewed daily by the QA Coordinator and DON/Designee for newly identified skin injuries. Any resident with newly identified skin injuries will be assessed by the DON or designee to ensure the revised policy and procedure was followed and plan of care updated. a. Residents with newly identified skin injuries will be added to the weekly wound rounds until area has resolved. b. All residents with skin injuries will be discussed weekly at the At-Risk meeting with the Interdisciplinary team (IDT). c. The results of the IDN and incident report reviews will be reported at the next scheduled QAPI meeting for continued review and oversight. 5. Completion Date: 2/11/22 and ongoing.	

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A Social Worker's (SW) note dated 2/1/21 read the resident would become a permanent health care resident based on her level of care needs effective 2/1/22. The SW spoke with the sister/Power of Attorney (POA) who agreed to vacate the assisted living (AL) apartment and have the resident remain in the health care unit (HCU).

Review of Resident #15's clinical record revealed on 2/9/21 the resident was without any existing skin conditions.

On 2/15/21, Resident #15 was observed with excoriation and denuded skin to the sacrum. A new order was obtained for Triamcinolone acetonide 0.025%, Miconazole 2%, Zinc oxide 20%; apply to sacrum every shift for moisture associated skin damage (MASD). This treatment ended 3/8/21.

A care plan problem dated 2/15/21 read; acquired moisture associated skin damage (MASD) to the sacrum, appears as denuded skin. The goal read; Area will resolve within the next 30 days. The interventions included; weekly skin checks and document the results. Treatment as ordered. Monitor for infection, redness, swelling drainage foul smell, decline in function, reduced mobility. This area was documented as resolved 4/12/21.

On 2/22/21, an email from the Director of Social Work stated the Director of Nursing (DON) had given permission to swap out the HCU hospital bed for the bed the resident owned in AL. Another email dated 2/24/21 was sent to the facility's staff stating a need to coordinate moving the resident's personal bed with all the belongings

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on it and her recliner from ALU to HCU so the room could be flipped.

During an interview with the Certifiecd Wound Care Associate (CWCA) on 1/6/22 at approximately 3:05 p.m., she stated the bed the resident had in AL was not a good choice for Resident #15 because it lacked the pressure reducing components she required, especially with the MASD they were treating. The CWCA was not exactly sure of the date the resident's personal bed was placed in her room but she stated it was a Friday and by Monday the midline buttock (gluteal cleft) Stage III pressure ulcer had developed. The CWCA also stated she would have issued the resident a pressure-reducing mattress overlay because the facility owned an abundance of them and they are readily available. The CWCA stated at the time the resident was observed with MASD, the resident was utilizing a standard pressure-relieving mattress to the bed and she felt it was appropriate for the resident since she required staff to provide turning and positioning and she was incontinent of her bowels and bladder coupled with multiple other co-morbidities.

During the phone interview with the complainant on 1/6/22 at approximately 9:30 a.m., the complainant stated she requested Resident #15's personal bed be moved to the HCU but at that time no one explained to her that the bed wasn't appropriate for the resident with her inability to turn and reposition herself. She stated once she was educated she allowed the facility to utilize the recommended bed.

An interview was conducted with the DON on 1/6/22 at approximately 5:20 p.m. to determine if

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she spoke with the POA to educate her why use of the resident's AL bed was not in the resident's best interest especially since she had skin impairment. The DON stated the POA declined to continue with use of the HCU bed, but not that she gave the POA beneficial reasons for the resident to use the HCU bed.

The clinical record revealed a wound care note dated 3/5/21 at 14:23, which read; midline buttock (gluteal cleft) presents with a full thickness open area with 100% granulation tissue. No drainage and the skin surrounding the open area is intact. The skin evaluation form dated 3/5/21 described the midline buttock (gluteal cleft) as measuring 3.0 centimeters (cm) by width 2.0 centimeters and depth of 0.8 centimeters. The wound was classified as a healing stage III pressure ulcer. The treatment ordered read; Clean the midline buttock (gluteal cleft) with normal saline, pat dry, apply Solosite wound gel, apply gauze and cover it with a foam dressing daily and as needed. (This treatment ended 3/15/21).

On 3/7/21, a nurse's note read; air mattress overlay functioning, which was a nursing judgement and did not require a physician's order.

On 3/15/21 the midline buttock (gluteal cleft) presented wound had deteriorated. It presented with 60% granulation tissue and 40% yellow slough and measured length 4.0 centimeters by width 1.0 centimeters by 0.3 centimeters. There was no drainage. The sacrum was with denuded skin. The treatment order dated 3/16/21 read; cleanse the midline buttock (gluteal cleft) with normal saline, pat dry, apply Santyl to the wound bed, apply Triad to the periwound and cover with

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a foam dressing daily and as needed.

A care plan dated 3/29/21 read; Pressure Ulcer present Gluteal Cleft stage III, related to bed change. The goal read; Pressure ulcer will be without signs/symptoms of infection through the next review. The interventions read; nurse to measure and monitor wound status, progression or deterioration every week. Notify MD and family of changes. Treatment as ordered. Dietary consult to consider nutrition, hydration healing factors. Supplements as ordered. Frequent turning and repositioning to off-load throughout each shift. Pressure relieving device in wheel chair (gel cushion), Pressure reducing mattress (AP+). Float heels in bed.

The 4/22/21 skin evaluation revealed the midline buttock (gluteal cleft) presented with 100% granulation tissue but measured; length 3.9 cm by width 3.0 cm by depth 0.6 cm. The treatment was changed to cleanse the midline buttock (gluteal cleft) with normal saline, pat dry, and apply Santyl to the wound bed pack lightly with Maxorb II plain cut to the size of the wound. Apply Triad to the periwound. Cover it with a foam dressing, change daily and as needed. The wound remained classified as a healing stage III.

On 6/21/21 Resident #15's pressure ulcer again presented with deterioration after it had shown improvement 4/26/21 through 6/18/21. The 6/21/21 skin evaluation revealed the midline buttock (gluteal cleft) presented with 70% granulation tissue and 30% slough with exposed muscle. A note stated there was a small amount of drainage. The wound measured; length 4.0 cm by width 3.0 cm by depth 1.5 cm. The note stated to continue with the same treatment

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ordered 6/18/21. The treatment read; to cleanse the midline buttock (gluteal cleft) with normal saline, pat dry, apply Medi-honey calcium alginate - honey; cut to the size of the wound. Pack lightly fluffed dry 4x4 gauze and cover. Then apply skin prep to the peri-wound and cover with foam dressing, change every three days and as needed. The wound was upgraded to a stage IV.

The clinical record revealed an order dated 6/18/21, which read; a low air loss/alternating air mattress to the bed to assist with healing of the sacrum wound.

The facility's policy titled; Wound Care Protocol with a revision date of 9/9/21 read on page 6; for a stage II pressure ulcer apply an air pro mattress (a mattress with air cells that expand and contract on an alternating basis to continually reduce pressure) to the bed. Based on the facility's policy information Resident #15 was not advanced to and placed on the air pro mattress on 3/5/21 and instead placed on a mattress overlay (a water, gel, air, or foam device applied on top of a mattress to prevent pressure ulcers) on 3/7/21.

The 6/28/21 skin evaluation indicated further deterioration of the midline buttock (gluteal cleft) pressure ulcer. It presented with 70 % granulation tissue and 30% yellow slough with exposed muscle. There was a small amount of drainage and an odor. The wound measured; length 4.0 cm by width 3.0 cm by depth 1.5 cm. The note stated to continue with the same treatment ordered 6/18/21. The treatment read; to cleanse the midline buttock (gluteal cleft) with normal saline, pat dry, apply Medi-honey calcium alginate - honey; cut to the size of the wound.

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Pack lightly fluffed dry 4x4 gauze and cover. Then apply skin prep to the peri-wound and cover with foam dressing, change every three days and as needed. The wound was upgraded to a stage IV.

On 7/5/21 the skin evaluation revealed with further deterioration of the midline buttock (gluteal cleft) pressure ulcer. It presented with 60% granulation tissue and 40% yellow slough with exposed muscle. There was serosanguinous drainage and no odor. Undermining was observed at 9 o'clock 2.2 cm, 12 o'clock 3.5 cm, and at 6 o'clock 0.8 cm. The wound measured; length 4.4 cm by width 2.0 cm by depth 2.0 cm. The note stated new treatment orders were received. The treatment read; to cleanse the midline buttock (gluteal cleft) with normal saline, pat dry, apply Santyl to the wound bed pack lightly with Maxorb II plain cut to the size of the wound. Then apply z-guard and skin prep to skin where the foam dressing will be placed, cover with foam dressing, change every day and as needed. The wound was upgraded to a stage IV.

On 7/9/21 at the POA's request the resident was transferred to a local emergency department where she was admitted and diagnosed with MRSA of the wound. The resident returned to the facility 7/13/21.

On 7/28/21, the resident began wound evaluations/treatment at a local wound care clinic and continues the service.

On 1/5/22 at approximately 12:45 p.m., just before the resident was transferred to the wound care clinic, an observation of wound care was made. The wound measured by sight at

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approximately length 4.0 centimeters by width 1.0 centimeters. The depth couldn't be estimated but at eleven o'clock, dark tissue was observed and the wound bed contained dark red tissue. There was no drainage and no odor. The resident tolerated the procedure without moaning, hitting or indications of discomfort.

During the survey week 1/4/22 through 1/6/22 observations were made of the staff turning and repositioning the resident with no resistance of care was observed but there was some indications of discomfort (grimacing, moaning).

An interview was also conducted with Licensed Practical Nurse (LPN) #2. LPN #2 stated Resident #15 is compliant with medication administration and wound care, staff feeds the resident and her intake is usually approximately 75% of most meals. LPN #2 stated she speaks calmly to the resident during care to prevent her from pushing and crying out. She also stated wedges and pillows are used to position the resident for pressure reduction to the pressure sore.

An interview was conducted with the primary day shift Certified Nursing Assistant (CNA) #3 on 1/61/21 at approximately 12:07 p.m. CNA #3 stated the resident doesn't resist care but does cry out when turn and repositioned especially over lumps of linens and she often experiences discomfort of the left foot when it is moved. CNA #3 stated the resident is only positioned on her back for meals and for approximately 20 minutes after the meal otherwise she is turned from side to side and a wedge is placed at her back and pillows between her legs. CNA #3 stated if the resident goes out for an appointment she goes by

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THE CHESAPEAKE	955 HARPERSVILLE RD NEWPORT NEWS, VA 23601

(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
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stretcher and she only sits in a low back wheel chair if she's going to the beauty shop. CNA #3 further stated the resident is fed all meals and has a good appetite.

On 1/6/22 at approximately 6:38 p.m., the above findings were shared with the Administrator, Director of Nursing and Wound Care Nurse. An opportunity was offered to the facility's staff to present additional information but they declined.

The information below was obtained on 1/19/22 at (https://www.ncbi.nlm.nih.gov/books/NBK326430/).
Pressure-relieving mattresses and support surfaces can lower the risk of pressure ulcers. There are now many different products that can be used in hospitals, nursing homes or at home. Most of them offer especially soft surfaces or alternating pressure.
Special foam mattresses can be used to provide a soft surface, for example. These distribute the pressure over a larger surface area, reducing the pressure on especially vulnerable parts of the body. One drawback of very soft mattresses is that they can make it more difficult for people to move themselves. If they sink into the mattress, it can be harder for them to prop themselves up and change positions. This is a problem especially for weaker people who would actually still be able to change their position on their own. Therefore, it makes sense to check what kind of mattress is most suitable.

Special mattresses known as alternating pressure mattresses are also commonly used and can help to prevent pressure ulcers. These mattresses have several chambers that are

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automatically filled with different amounts of air. The air pressure usually changes several times an hour to relieve pressure on different parts of the body. Alternating pressure mattresses are most often used for patients who have an especially high risk of developing pressure ulcers - such as patients in intensive care who are on a ventilator and can't move on their own.

The information below was obtained on 1/18/22 from https://www.woundsource.com/patientcondition/moisture-associated-skin-damage-masd# Moisture-associated skin damage (MASD) is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus.

The information below was obtained on 1/18/22 from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/pressure_ulcer_prevention/webinars/webinar6_pu_woundassesst.pdf

* A stage III Pressure Ulcer: Definition ·
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Some slough may be present.
·May include undermining and tunneling
.
Description The depth of a stage III pressure ulcer
varies by anatomical location. - The bridge of the nose, ear, occiput, and
malleolus do not have "adipose"
subcutaneous tissue and stage III ulcers can be shallow.

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- In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. *Bone/tendon is not visible or directlypalpable

A Stage IV Pressure Ulcer: Definition o Full thickness tissue loss with exposed bone, tendon, or muscle - Slough or eschar may be present.
o Often include undermining and tunneling Description o The depth of a stage IV pressure ulcer varies by anatomical location. - The bridge of the nose, ear, occiput, and malleolus do not have "adipose" subcutaneous tissue and stage IV ulcers can be shallow.
o Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule), making osteomyelitis or osteitis likely to occur.
o Exposed bone/tendon is visible or directly palpable.

An Unstageable Pressure ulcer: Definition o Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.
Description o Until enough slough and/or eschar is removed to expose the base of the wound, the true depth cannot be determined but it will be either a Stage III or IV.
o Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

*Tunneling. Tracts extending out from the wound.

COMPLAINT DEFICIENCY

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