STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	C 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH & REHAB CENTER, LLC	776 OAK GROVE RD CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/25/22 through 01/28/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Seven complaints were investigated during the survey The census in this 120 certified bed facility was 94 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 7 closed record reviews.	F 000	The creation and submission of this Plan of Correction serves as written validation of regulatory compliance. Preparation and submission of this plan does not constitute an admission or agreement by Oak Grove Health & Rehab Center (Provider) of the truth regarding the facts alleged or the correctness of the conclusions set forth by the survey agency. This plan of correction is solely prepared because of the requirements set forth by state and federal law, and to demonstrate the good faith attempts by the Provider to improve the quality of life for each resident entrusted to our care.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on compliant investigation, staff interviews, clinical record review and facility documentation review, the facility staff failed to follow professional standards of nursing for 1 of 34 residents (Resident #47) in a survey sample. The findings included: The facility staff failed to ensure blood pressures were taken prior to the administration of medication (Zanaflex) as ordered by the physician Resident #47 was admitted to the nursing facility on 06/03/21. Diagnosis for Resident #47 included but not limited to Myasthenia Gravis.	F 658	**F-658** *Cross-Reference: 12 VAC 5-371-200 (B) (D)* 1. Resident #47's medication regimen was reviewed at the time of discovery. The physician reviewed the clinical record and the resident and found resident #47 to be without any adverse effects related to the alleged deficient practice. The physician discontinued parameters connected to the	

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

William F. Davis LNHA — Facility Administrator — 2/18/22

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F 658	Continued From page 1 Resident #47's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 12/10/21 coded the resident's Brief Interview for Mental Status (BIMS) score 08 of a possible 15 with moderate impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #47 requiring total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and set-up help only with eating for Activities of Daily Living (ADL) care. Review of Resident's #47's Order Summary Report for January 2022 revealed the following order: Zanaflex tablet - give 2 mg tablet by mouth three times a day for muscle relaxer; hold for altered mental status/sedation or systolic blood pressure less than 100. During the review of Resident #47's blood pressure for the month of July 2022 revealed blood pressure was not taken three times a day prior to the administration of the medication Zanaflex on the following days: (01/02, 01/03, 01/04, 01/05, 01/06, 01/07, 01/08, 01/09, 01/11, 01/13, 01/14, 01/16, 01/18, 01/19 and 01/22/2022). An interview was conducted with License Practical Nurse (LPN) #5 on 01/26/22 at approximately 3:50 p.m. The LPN reviewed the above mentioned physician order for the administration of Zanaflex, then stated, "The resident's blood pressure should be taken three times a day prior to the administration of the medication Zanaflex."	F 658	aforementioned medication on 1/27/22. 2. All residents with medications with attached blood pressure parameters have the potential to be affected. An audit was done to identify residents who were on medications with attached blood pressure parameters by the nursing leadership team and was completed by 2/22/22. Any medications found to have blood pressure parameters that were not appropriate for the medication class were discussed with the provider and amended as ordered. 3. The nursing staff will receive re-education on the facility medication administration policy with a focus on orders with attached blood pressure parameters and documentation of the blood pressure reading with the administration of ordered medications by the clinical educator. 4. DON or designee will review new admission order listing report to ensure accuracy of orders as well as the medication administration	

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F 658	Continued From page 2 On 01/27/22 at approximately 1:10 p.m., an interview was conducted with the Director of Nursing (DON). The DON reviewed the Zanaflex order and stated, "Resident #47's blood pressure should have been taken prior to giving each dose of the Zanaflex." On the same day at approximately 3:00 p.m., the DON said she had spoken with Resident #47's physician who stated, "Resident #47's blood pressure should have been taken prior to giving each dose of Zanaflex because she was having low blood pressures during that time." A debriefing was held with the Administrator and Director of Nursing on 01/27/22 at approximately 4:50 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. Definitions: -Zanaflex is used to relieve the spasms and increased muscle tone caused by multiple sclerosis (MS, a disease in which the nerves do not function properly and patients may experience weakness, numbness, loss of muscle coordination and problems with vision, speech, and bladder control), stroke, or brain or spinal injury. Tizanidine is in a class of medications called skeletal muscle relaxants. It works by slowing action in the brain and nervous system to allow the muscles to relax (https://medlineplus.gov/druginfo/meds/a601121.html). -Myasthenia Gravis is a disease that causes weakness in your voluntary muscles. These are the muscles that you control. For example, you	F 658	report 5x per week for 6 weeks and then weekly thereafter for a period of 4 weeks. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. 5. Completion Date: **March 4, 2022**	

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F 658	Continued From page 3 may have weakness in the muscles for eye movement, facial expressions, and swallowing. You can also have weakness in other muscles. This weakness gets worse with activity, and better with rest(https://medlineplus.gov/druginfo/meds/a601121.html).	F 658		
F 687 SS=D	Complaint deficiency Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 resident (Resident #35), in the survey sample of 34 Residents who was unable to carry out activities of daily living receives the necessary services to maintain toenail care. The findings included: Resident #35 was originally admitted to the facility on 07/31/20. Diagnosis for Resident #35 included	F 687	**F-687** *Cross-Reference: 12 VAC 5-371-200 (B) (D)* 1. Resident #35 was seen by contracted facility podiatrist on 1/31/22 to receive foot care as needed. Podiatrist added resident #35 to the routine services list. 2. DON or designee inspected all current residents' toenails to ensure foot care and/or podiatry services have been provided as needed on 2/9/22. All variances noted were corrected by providing foot care and/or podiatry services. The podiatrist visited all residents on 2/13/22. 3. Nursing staff were re-educated on foot care on 2/9/22. The education focused on a review of	

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F 687	Continued From page 4 but not limited to other abnormalities of gait and mobility and Chronic Kidney Disease. The most recent Minimum Data Set (MDS) an annual with an Assessment Reference Date (ARD) of 12/04/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 9 which indicated moderate cognitive impairment for daily decision-making. Resident #35 was coded to require limited assistance of one staff with personal hygiene. The Care Plan revealed the following: I have an ADL Self Care Performance Deficit r/t my cognition. Goal: I will maintain current level of function in my adls (Activities of Daily Living) through the review date. Interventions: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During the initial tour on 1/26/2022 at approximately 10:29 AM., an interview was conducted with Resident #35. The surveyor asked the Resident if his toenails needed to be trimmed. He stated, "Yes." The surveyor then asked the resident if she could see his feet. He stated, "Yes." The Resident's nurse, LPN (Licensed Practical Nurse) #1 was asked to assist in removing the covers and socks from off of the Resident's feet. An observation of the resident's toenails on the right great toe revealed his toenails were long, thick and jagged. The toenails on the resident's left great toe appeared Jagged and long. His fourth toenail (on the left foot) appeared long and jagged and his second toenail appeared jagged (on the left foot). LPN #1 stated that she will put him on the podiatry list. On 01/26/22 at 12:19 PM. The surveyor was	F 687	the facility policy on foot care as well as the process for requesting podiatry services for residents for whom the staff are unable to provide sufficient foot care by the director of social services and the clinical educator. 4. DON or designee will randomly conduct 5 skin assessments weekly for 6 weeks to ensure foot care and/or podiatry services have been provided to current residents. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. 5. Completion Date: **March 4, 2022**	

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F 687	Continued From page 5 approached by LPN #1. She stated, "The Podiatrist comes on a case by case basis. We can put him (Resident #35) on the list. I talked to MDS (Minimum Data Set) staff about getting him on the list for an appointment." Received the podiatry list dated 11/09/21 from the administator via email on 1/28/22. A notation at the bottom of the podiatry list reads: Next earliest appointment date 2/07/22. Resident #35's name was not on the list. On 1/28/22 at 2:15 PM a pre-exit interview was conducted via telephone with the administrator and the DON. The surveyor asked what are your expectations concerning Resident #35 and is your nursing staff allowed to cut residents' toenails if they're non diabetic. The administrator stated, " The SW (Social Worker) is notified and schedules ancillary services. Yes." (nurses are allowed to provide toenail care if a resident is not diabetic).	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to ensure one Resident (Resident #45) in the survey sample of	F 689	**F-689** 1. Resident #45's legal guardian gave consent for the resident to be transferred to a facility that permits smoking on 2/10/22. Resident is scheduled to transfer to a facility, which permits smoking by 3/3/22. 2. No other residents had the potential to be affected by this identified practice. The facility remains a non-smoking facility. All new admissions will be	

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F 689	Continued From page 6 28 residents did not smoke inside the facility. The findings included: Resident #45 had a re-admit date of 12/09/21. Resident #45 was re-admitted with diagnoses which included muscle weakness, paraplegia, neuromuscular dysfunction of bladder, schizoaffective disorder, and adjustment disorder. Resident #45 was assessed as requiring maximum assist with Activities of Daily living. Resident was noted to have a colostomy. Resident #45 had a care plan dated 11/05/21 which indicated: Focus- Smoking paraphernalia no-complaint with smoke free facility; Goal- The resident will have an understanding of the effects of being non complaint with smoke free facility. Interventions- Educate and encourage of the risk verses benefits of not following non-smoking facility policy. Resident #45 was observed on 1/25/22 at 2:35 p.m. in bed. Resident #45 was able to speak and carry on a conversation. Resident #45 was observed in bed on 1/26/22 at 9:15 a.m. in bed. Resident had completed his breakfast meal and ate 100%. A Social Worker's note dated 1/24/22 at 13:29 (1:29 p.m.) indicated: " SW spoke with admin who informed resident was smoking again in his room. Guardian was made aware. Non emergent (police) were called out, they were unable to assist in room search but did stand outside the door as backup. Administrator, Unit Manager and SW entered the room to assist in a room search. Resident was informed he wasn't smoking but had a vape pen in his hand. Once pointed out by	F 689	educated on this policy prior to admission. 3. All staff were re-educated on the non-smoking policy and what to do if someone was found to be in violation of said policy on 2/9/22 by the facility administrator. 4. DON or designee will randomly audit 3 new admissions weekly for 6 weeks to ensure residents and/or their responsible parties acknowledge the facility smoking policy. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. Completion Date: **March 4, 2022**	

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F 689	Continued From page 7	F 689		

SW, Administrator informed resident he will need to had over. Resident refused stated that "he does not see why he needs to stop doing the things he likes to do." The administrator continued to educate resident that smoking is prohibited in the facility. SW informed resident that the guardian is still working on restoring his rights. SW also informed that multiple group homes and no beds or he is on there do not readmit list because of his behaviors. When requested to hand over his smoking device resident refused and stated he wanted to be sent out to he hospital, when asked why he stated it was his bladder. A call was placed to guardian to make him aware. Resident refused to be sent out."

A Social Worker's note dated 1/18/222 at 17:20 (5:20 p.m.) indicated: " SW called no emergent police line, per police officers there is nothing that they can do at a state level because marijuana is legal in the state of Virginia. Per officers this would be something that needs to be handled at an administrative level. Cops wouldn't even assist with room search they only stood outside door, while an attempt to search room. Resident informed he was not smoking and he was only burning SAGE. Resident refused search. Social worker requested the red lighter that was on the bed and the sage. Resident handed over both items. SW educated resident that this a non-smoking facility and we will be initiating a 30 day dc notice. SW will issue a 30 day notice once a place for him to go, SW have been working diligently these last couple of days to find placement for this gentlemen but once they see the behavior notes facilities are very apprehensive. Officers suggest if you get into a physical altercation with resident file a police

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F 689	Continued From page 8 report. Build a case." During an interview on 1/27/22 at 2:36 p.m. with the SW, she stated, the doctor had completed a competency assessment on Resident #45 and resident is competent. SW stated getting full support from Guardian had been troublesome. When asked how resident receive smoking material, the SW stated, they can not figure it out. Resident have wounds and refuse to be treated. They think he has items hidden under his bottom. During an interview on 1/27/22 at 3: 10 p.m. with the administrator she was asked how resident was able to get smoking material into the building since he was not able to get up on his own. The administrator, stated she was not sure because resident did not have that many visitors. During an interview on 1/28/22 at 9:21 a.m. with the Unit Manager she was asked how resident got smoking material into building. the Unit Manager stated, they do not know. Cameras set up out side did not capture the area where Resident #45's room is located. A facility Smoking Policy: indicated- This facility is a non- smoking facility.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695	**F-695** *Cross-Reference: 12 VAC 5-371-200 (B) (D)* 1. Resident #23's oxygen tubing was immediately changed, labeled and dated on 1/27/22. Upon discovery on 1/27/22, the oxygen was set to 4 LPM as ordered.	

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F 695	Continued From page 9 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to follow the physician order for the oxygen flow rate, monitor the flow rate and failed to label and date the oxygen tubing for 1 of 34 residents (Resident #23) in the survey sample. The findings included: Resident #23 was originally admitted to the nursing facility on 03/11/21. Diagnosis for Resident #23 included but not limited Diabetes Mellitus and Respiratory Failure. Resident #23's Minimum Data Set (MDS-an assessment protocol) a quarterly revision assessment with an Assessment Reference Date (ARD) of 11/17/21 coded Resident #23 an 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive skills for daily decision-making. In addition, under respiratory treatments was coded for the use of oxygen therapy. Resident #23's person centered care plan had a focus which read; Resident #23 is on oxygen therapy. The goal read; will be free from signs and symptoms of hypoxia. One of the interventions included; administer oxygen as ordered. The care plan also reads: The resident has a behavior problem: Turns up 02. Goals: Resident #23 will have an understanding of the effects of turning up 02 thru the next review date. 2/13/22. Initiated on 11/19/21. Interventions: Educate and encourage the risk verses the	F 695	Resident will continue to be monitored for compliance. 2. DON or designee will complete a 100% audit of all residents who receive oxygen treatments and ensure the oxygen is being administered as ordered and tubing is appropriately changed, labeled and dated on 2/21/22. Any variances will be immediately addressed with education being provided as needed. 3. Licensed nursing staff will be re-educated on the facility oxygen administration policy to include a focus on changing, labeling and dating tubing as well as monitoring the settings on the oxygen to ensure administration is being given as ordered. 4. DON or designee will randomly audit 3 residents with orders for oxygen to ensure proper settings and proper dating of tubing weekly for 6 weeks to ensure compliance. Aggregate findings	

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F 695	Continued From page 10 benefits of the 02 setting. Review of Resident #23's Order Summary Report for January 2022 included the following order: Oxygen at 4 LPM Via nasal cannula every 24 hours as needed for Shortness of Breath with a start date of 12/29/21. Change O2 tubing and set-up weekly every night shift every Monday for SOB (Shortness of Breath) Label tubing with date when changed. Order date: 10/14/21. Start Date: 10/18/21. During the initial tour on 1/26/22 at approximately 4:34 PM., Resident #23 was observed lying in bed with oxygen on at 7 liters per minute via nasal cannula (n/c) with humidification. No label/Date seen on O2 tubing On 1/27/22 at approximately 8:51 AM., Resident lying in bed with his oxygen at 7 liters per minute via n/c with humidification. No label/Date seen on O2 tubing. On 1/27/22 at approximately 8:57 AM an interview was conducted with LPN (Licensed Practical Nurse) #3 concerning resident #23's 02 level. He stated, "It should be 4 liters." On 1/27/22 at approximately 1:36 PM., an interview was conducted with LPN (Licensed Practical Nurse) #4. She stated," Resident #23 turns up his own O2. He is care planned as being non-compliant with his O2." She was asked by surveyor if Resident's oxygen flow rate should be monitored due to his behavior. She stated, "Yes." Policy: Oxygen Administration (all routes) Policy.	F 695	will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. Completion Date: **March 4, 2022**	

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F 695	Continued From page 11 Department: Clinical: Respiratory. Effective Date: 1/23/2017. Last Revision Date: 12/16/2019. Policy: Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. In an emergency situation, clinicians may administer oxygen and obtain a provider's order as soon as practicably possible after patient stabilization or transfer. Equipment: Regulator/Flow meter. Procedure: Verify Provider order. Preparation and Equipment: Connect the regulator and flow meter, open set to desired flow. Administration via nasal cannula: Set flow rate. Cleaning: Change tubing, mask, and cannula weekly and document according to facility policy. On 1/28/22 at approximately 9:25 AM a telephone interview was conducted with the administrator and DON concerning the above. The facility staff did not present any further information. This is a complaint deficiency!	F 695		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726	**F-726** *Cross-Reference: 12 VAC 5-371-210 (B, C, E)* 1. Staff member identified provided the documentation to support ability to practice as a practical nurse on 1/28/22. Staff member scheduled to take NCLEX on 3/9/22. Staff member was assigned facility orientation with the ADON and a graduate nurse skills checklist was completed on 2/3/22.	

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F 726	Continued From page 12 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, staff interviews, and review of facility documents, the facility staff failed to have a procedure in place to ensure that a presumed Graduate Nurse (GN) had a license or authorization to practice in the state prior to hiring, starting orientation and rendering care to residents in the facility. The findings included: An interview was conducted with the Director of Nursing and Administrator on 1/28/21 at approximately 5:45 p.m. regarding the complaint that they had nurses right out of school without proper credentials working in the facility. The Director of Nursing stated they didn't have anyone working as a nurse who didn't meet the requirements to work as a graduate Nurse.	F 726	2. An audit was completed within the facility on 2/1/22 and no other staff members were affected by this practice. 3. DON, HR, and the nursing leadership team were re-educated on the graduate nurse policy by the facility administrator to ensure all necessary documents are provided at time of hire and included in employee personnel file. Nursing leadership re-educated on orientation checklist and facility orientation program. 4. NHA or designee will randomly audit 4 new hires monthly for 3 months to ensure orientation and hiring practices are being followed. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. Completion Date: **March 4, 2022**	

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F 726	Continued From page 13 Review of one presumed Graduate Nurse (GN) Personnel record revealed the staff was originally hired 10/18/21 and rehired 12/20/21. Further review of the personnel records didn't reveal a license to practice as a practical Nurse neither a letter from the Department of Health Professions authorizing the individual the right to practice as a Practical Nurse applicant for 180 days or until results were received from the first licensing examination. An interview could not be conducted with the Human Resource Director for she was out of town during the survey. On 1/28/21 at approximately 2:25 p.m., an interview was conducted with the staff who currently held the proper credentials to practice as a practical nurse applicant as of 1/19/22 with a testing date of 3/9/22. The staff member stated he was supposed to complete his nursing classes October 2021 but he hadn't completed all clinical hours necessary for he had been out sick. He stated he had to wait for the specific clinical rotation to come back around therefore; there was a delay in completion of the practical nursing program. The staff stated he completed the graduate practical nurse orientation in the nursing facility and staff taught him to complete wound care, pass medications, obtain vital signs, conduct a fall assessment and other competent nurse duties. The staff stated sometime in November he resumed the practical nurse program to complete the required clinical rotation at which time he stopped working in the nursing facility. The staff stated it was approximately 12/19/21 that he was rehired as a graduate Nurse by the nursing facility and he has worked continuously since then.	F 726		

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On 1/28/21 at approximately 2:30 p.m., the above findings were shared with the Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.

The below information was obtain from the following website on 2/7/22: https://law.lis.virginia.gov/admincode/title18/agency90/chapter19/section110/

A. The board shall authorize the administration of the (National Council Licensure Examination) NCLEX for registered nurse licensure and practical nurse licensure.

B. A candidate shall be eligible to take the NCLEX examination (i) upon receipt by the board of the completed application, the fee, and an official transcript or attestation of graduation from the nursing education program and (ii) when a determination has been made that no grounds exist upon which the board may deny licensure pursuant to § 54.1-3007 of the Code of Virginia.

C. To establish eligibility for licensure by examination, an applicant for the licensing examination shall:

1. File the required application, any necessary documentation and fee, including a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia.

2. Arrange for the board to receive an official transcript from the nursing education program that shows either:

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F 726	Continued From page 15 a. That the degree or diploma has been awarded and the date of graduation or conferral; or b. That all requirements for awarding the degree or diploma have been met and that specifies the date of conferral.	F 726		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, family interview, staff interviews, and clinical record review, the facility staff failed to to ensure a resident exhibiting resistive behaviors secondary to a history of pain related trauma received person-centered services to support and promote mental and physical well-being which resulted escalated behaviors and a significant decline in mental and physical functioning for 1 of 34 residents (Resident #36), in the survey sample. The findings included: Resident #36 was originally admitted to the facility 10/11/21, and readmitted 12/3/21, after an acute	F 742	**F-742** *Cross Reference: 12 VAC 5-371-220 (A, C)* 1. Resident #36 no longer resides in the facility. 2. Residents exhibiting resistive behaviors secondary to needing behavioral health services or pain management had the potential to be affected. 3. DON or designee will review residents with resistive behaviors and ensure psychiatric, pain management consults have been requested for recommendations, and that those recommendations have been reviewed with a physician and completed as ordered. Licensed nursing staff will be educated on managing resistive behaviors and finding alternatives or compromises to care approach to ensure person centered-care is delivered.	

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F 742	Continued From page 16 care hospital stay. The current diagnoses included; Cerebral palsy/paraplegia, status post Right hip fracture, Chronic pain, an Adjustment disorder with anxiety and Generalized Weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/9/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing and locomotion, extensive assistance of two people with bed mobility, transfers, personal hygiene and dressing, extensive assistance of one person with toileting, supervision after set-up with eating. During an interview with Resident #36 on 1/25/22 at approximately 1:35 p.m., the resident began to cry and speak very rapidly because she felt the staff doesn't answer her call bell timely, doesn't speak to her, her friend or parents appropriately The resident also stated the staff is causing her mental anguish because of their attitudes towards her. The resident further stated she came to the facility to strengthen her body so she could return home requiring one person assistance with bed mobility, activities of daily living (ADL) and transfers from the bed to a chair. The resident further stated at some point during the hospitalization prior to admission to the nursing facility she sustained a right hip fracture and later other fractures in which she was unaware of until she experienced excruciating pain during turning and repositioning. The	F 74:	4. DON or designee will audit documented resistive behaviors 5x per week for 6 weeks and then weekly thereafter for a period of 4 weeks. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. Completion Date: **March 4, 2022**	

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resident also stated on one occasion she was put in the Hoyer lift while she was fractured and the pain was indescribable. The resident expressed since the fractures and the Hoyer lift events she has had great fear of excruciating pain when staff approaches her and often prior to staff touching her to provide any type of care. The resident further stated she occasionally uses the call bell to ask for assistance because she knows she needs ADL care but because of fear of pain she rejects the care when the staff finally arrives. The resident also stated sometimes she requests pain medication prior to receiving care but most of the time she simply rejects care for fear of experiencing great pain. The resident stated her most recent method for dealing with having staff assistance has been to eat very little and decrease her fluid intake so she will not eliminate very often but; as a result she has suffered frequent episodes of constipation.

Observations were made on the resident on 1/25/21 at approximately 1:35 p.m., and again on 1/27/28 at approximately 4:45 p.m., the resident appeared unbathed, sweaty, with dishevel hair and the bed linens were notably soiled. The window was opened because the resident stated she was too warm.

A care plan had a problem dated 12/7/21 which read; resident has behaviors: as evidenced by; refuses Adl care, turn and reposition, dressing changes, weights, Physician orders, hair facial hairs removed, to be changed when soiled, can be accusatory, skin assessment related to severe anxiety that debilitates her functional status. The goal read; resident will have fewer episodes of refusal by the review date, 5/22/22. The interventions included; Anticipate and meet the

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F 742	Continued From page 18 resident's needs. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Educate and encourage of the risk verses benefits of skin assessments, of being accusatory, of being changed when soiled of removing facial hairs, of refusing MD orders, encourage and allow the resident to express feelings appropriately. Explain all procedures to the resident before starting and allow the resident to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Another care plan problem dated 12/7/21 read; resident has potential for acute/chronic pain related to Chronic Physical Disability Cerebral Palsy, and a right femur fracture. The goal read; the resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date 5/22/22. The interventions included; Administer analgesia/medications per orders. Anticipate the resident's need for pain relief and respond to any complaint of pain as needed. Assess/document for probable cause of each pain episode. Remove/limit causes where possible. Assess/record/report to nurse loss of appetite, refusal to eat and weight loss. Assess/record/report to nursing any signs/symptoms of non-verbal pain. Implement non-pharmacological interventions to release the pain like Distraction techniques, Relaxation and Breathing exercises, music therapy, Re-position. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care.	F 742		

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Notify MD as needed with changes. Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to signs/symptoms or complaints of pain or discomfort.

Review of the clinical record revealed Resident #36 had rejected care since admission to the facility and when the resident was initially approached by Social Services to receive support from a psychologist the therapy was rejected but agreed upon on at a later date.

Further review of the clinical record revealed volumes of documentation of the resident's episodes of rejecting services yet interventions; such as staff education to encourage resident trust and acceptance of services or professional services such as increased psychotherapy with a focus on the resident's indicators of distress using a person-centered approach were not documented, neither were referrals to provide ongoing assessment and symptom management, and emotional/spiritual support documented.

The clinical record had a progress note from the Psychological practitioner which indicated on 10/27/21 the resident wasn't available to be seen. Another opportunity to treat the resident wasn't made until 1/26/22. Review of the 1/26/22 notes resulted in no recommendations for changes in therapy, medications of the treatment plan even with the constant rejection of care, screaming, and other indicators of mental distress.

An interview was conducted with the Occupational Therapist (OTR) on 1/27/22 at approximately 1:00 p.m. The OTR stated the resident received occupational therapy services

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F 742	Continued From page 20 10/11/21 through 10/22/21 and 10/29/21 through 11/8/21 and because the resident was currently long term care she wasn't receiving any type of therapy but could be screened for physical therapy services. The OTR also stated the resident's dad wanted her to roll in bed with one person originally but it wasn't possible for sometimes it required three to four people here to roll the resident. The OTR stated she recognized the resident's greatest obstacle was her anxiety therefore; she talked about techniques to control the her anxiety using singing, praying, the resident offering cues and the resident's anxiety got better but not rolling still wasn't doable with one person. The OTR stated she continued to work with the resident in strengthening to assist with rolling and desensitization related to having the immobilizers in place for the fractures. The OTR finally stated the resident's anxiety prevented further progression in occupational therapy for the resident wasn't capable of getting past her anxiety exhibited as pain to warrant continued therapy services and she stated based on her interactions with the resident she didn't believe as long as the resident was with the level of anxiety she currently exhibits therapy services could be rendered. 01/28/22 07:59 a.m., an interview was conducted with the parents of Resident #36. They expressed their concerns that the facility had plans to discharge the resident and hadn't worked effectively towards their goal of one person assistance for bed mobility and transfers in the community. The parents expressed their desire for their daughter to leave the nursing facility but at the currently level of dependence they didn't have to community resources to meet her needs. They felt the therapist provided the services they	F 742		

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F 742	Continued From page 21 felt were appropriate for the resident such as speech therapy instead of physical therapy On 1/27/22 at approximately 2:55 p.m., an interview was conducted with the primary physician for Resident #36. The physician stated the resident has had great anxiety related to pain when staff touches her resulting in the resident's inability to receive needed care and services. The physician further stated this anxiety had been overshadowing her entire stay at the facility therefore the primary physician stated he would institute a team approach to maximize resident's relief of her pain which seems to be exacerbated by her overall anxious disposition. His plans and options of treatment included treatment of her anxiety by seeking out further assistance from psychological services, in the form of more frequent visits from psychologist as well as the utilize the psychiatric nurse practitioner. The physician also stated he would request input for ongoing chronic pain management from a physician of physical medicine and rehabilitation and he would review the medication for changes. On 1/27/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and neither were concerns voiced.	F 742		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756	**F-756** *Cross Reference: 12 VAC 5-371-300 (D)* 1. The physician for Resident #92 was notified of the missed GDR and there were no recommendations or reductions made at the time of review.	

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F 756	Continued From page 22 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview the facility, the failed to ensure 1 of 34 Residents (#92) in the survey sample was seen by the pharmacist for Medication Regimen	F 756	2. Any resident with pharmacy recommendations has the potential to be affected. The Administrator, Nursing Leadership Team, Medical Director on 2/11/22 to ensure pharmacy recommendations were completed, completed a 30-day look back of the pharmacy recommendations. If any pharmacy recommendation was determined not to be completed, the physician was notified to obtain orders for further direction. 3. The Regional Director of Clinical Services and Administrator educated the Director of Nursing and Assistant Director of Nursing on 2/9/22 regarding the pharmacy recommendation process of running the summary report and reviewing the recommendations with the physician. 4. DON or designee will audit the pharmacy recommendations weekly to determine if they are being addressed and completed timely. The consultant pharmacist will send the	

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F 756	Continued From page 23 Review (MRR) on a monthly basis. The findings included: The facility staff failed to review Resident #92's medication regimen for the month of August 2021. Resident #92 was admitted to the facility on 07/07/21. Diagnosis for Resident #92 included but not limited to Major Depressive disorder and Anxiety disorder. Resident #92's Minimum Data Set (MDS), a quarterly Assessment Reference Date (ARD) of 01/09/22 coded the resident with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The MDS coded Resident #92 requiring extensive assistance of one with bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing for Activities of Daily Living (ADL) care. Resident #92's comprehensive care plan documented Resident #92 is on a antipsychotic therapy related to depression. The goal set for the resident by the staff is to remain free from adverse effects of antipsychotic therapy. One of the interventions/approaches the staff would use to accomplish this goal is to consult with the pharmacist, physician and the Medical Director for a gradual dose reduction if appropriate. Review of Resident #92's Order Summary Report revealed the resident was taking 14 scheduled medication to include Klonopin and Seroquel. Review of Resident #92's clinical record did not include a pharmacy progress note for August 2021. The DON said she was not able to locate	F 756	Administrator a monthly audit of any outstanding pharmacy recommendations to validate the weekly audit the audit will be completed weekly for four weeks and then monthly thereafter. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Facility Administrator will be responsible for ensuring compliance. Completion Date: **March 4, 2022**	

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	495215	A. BUILDING _____ B. WING _____	C 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 24 the pharmacy review for August 2021. A debriefing was held with the Administrator and Director of Nursing (DON) on 01/27/22 at approximately 4:50 p.m. The DON stated, "The pharmacist is expected to the resident on a monthly basis." Definitions: Klonopin is used alone or in combination with other medications to control certain types of seizures. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines. It works by decreasing abnormal electrical activity in the brain (https://medlineplus.gov/drug). Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/drug).	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	**F-842:** *Cross-Reference 12 VAC 5-371-360 (J) & (K)* 1. Resident #298 no longer resides in the facility. Facility acquisition to new ownership occurred on 11/1/20.	

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F 842	Continued From page 25 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	2. All residents residing in the facility prior to 11/1/20 had the potential to be affected. Facility Medical Records Custody Agreement outlines the agreement set forth prior to the facility acquisition. 3. No education or policy revision is warranted at this time. 4. NHA or designee will maintain access to former EMR to ensure access to resident records as needed. Completion Date: **March 4, 2022**	

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F 842	Continued From page 26 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete record for one of 34 residents in the survey sample; Resident #298. During the course of the survey from 1/25/22 through 1/28/22 a surveyor was not able to retrieve records for one closed record resident through the facility's current eMAR (Electronic Medication Administration Records) system called "My Unity." The administrator assured the surveyor that she would be able to get the requested records for Resident #298. The records were received upon request. However, when requesting wound care information the records provided by the facility did not contain adequate information. A conclusion was made concerning Resident #298's stage 2 pressure ulcer once hospital records were requested and	F 842		

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F 842	Continued From page 27 received by VDH/OLC (Virginia Department of Health/Office of Licensure and Certification). On 1/28/22 at 9:25 AM the administrator stated, "With the user rights for the eMAR (Electronic Medication Administration Records) system at each Sentara building was given to one person on sight. They are not able to add additional users. We are not able to do that through my Unity." The findings included: Resident #298 was admitted to the facility on 07/13/20. Diagnosis for Resident #298 included but not limited to Hypertension and Atrial Fibrillation. The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 07/20/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.This indicated Resident #298's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as total dependence of two persons with bed mobility, dressing, toilet use and personal hygiene. Resident was coded as Independent with eating-set up help only. In section " M" (Skin Conditions). Risk of Pressure Ulcers/Injuries? Coded as 1, meaning Yes. The Medical Records Custody Agreement reads: This Medical Records Custody Agreement is	F 842		

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F 842	Continued From page 28 entered into to be effective as of November 1, 2020 by and between the entities set forth on the signature page under the heading "Saber" (Collectively, "Saber"), and the entities set forth on the signature page under the heading "Sentara" (Collectively, "Sentara"). On 1/28/22 at approximately 9:25 AM a telephone interview was conducted with the Administrator and DON concerning the above. The facility did not present any further information.	F 842		