STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 05/07/19 through 05/09/19. The facility was not in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations,	E 007		6/17/19

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

Electronically Signed | 05/21/2019

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E 007	Continued From page 1 including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities identified population at risk during an emergency, services the facility would be able to provide during an emergency and delegations of authority during an emergency. The findings included: During an interview on 05/08/19 at 10:58 A.M. with the Maintenance Director, he was asked for documentation of the facilities identified population at risk during an emergency, the services the facility could provide during an emergency and the delegation of authority during an emergency. The Maintenance Director stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency. Nor did the facility have documentation of delegation of authority during an emergency and the services that the facility would be able to provide during an emergency event. The facility staff failed to have documentation of the facilities identified population at risk, the services the facility would provide during an emergency and documentation of delegation of authority during an emergency.	E 007	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. E007 1. The facility has documented identified population at risk, the services the facility would provide during an emergency and delegation of authority during an emergency. 2. The facility has an Emergency Plan which includes documentation of identified population at risk, the services the facility would provide during an emergency and delegation of authority during an emergency. 3. Facility staff will be educated on: " Identified population at risk " Services provided by the facility during an emergency	

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E 007	Continued From page 2	E 007	" Delegation of authority during an emergency 4. The Administrator will complete a random monthly review of the Emergency Preparedness Plan to ensure that there is documentation of the facility□s identified population at risk, the services provided during an emergency by the facility, and delegation of authority during an emergency. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the	E 015		6/17/19

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E 015	Continued From page 3 following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan address emergency fire detection. The findings included:	E 015	E015 1. The facility has an emergency preparedness plan to address emergency fire detection. 2. The facility implements a □Fire Watch Program□ for emergency fire detection during an emergency.	

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E 015	Continued From page 4 The facility emergency preparedness plan failed to have documentation of emergency fire detection during an emergency. During a review of the emergency preparedness plan with the Maintenance Director on 5/8/19 at 11:21 A.M. he was asked for documentation for fire detection during an emergency. The Maintenance Director stated " The Maintenance director stated he did not have a "Fire Watch Program" for the facility's emergency fire detection system. The facility staff failed to provide documentation of emergency fire detection.	E 015	3. Facility staff will be educated on: " Fire Watch Program for emergency fire detection during an emergency 4. The Maintenance Director will complete a random weekly review to ensure that staff are knowledgeable about the Fire Watch Program. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency	E 024		6/17/19

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E 024	Continued From page 5 staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for the use or non use of volunteers during an emergency. The findings included: During an interview on 5/8/19 at 11:25 A.M. with the Maintenance Director he stated, the facility had some volunteers who assist residents, however, the facility had not developed policies and procedures for the use of volunteers during emergency preparedness activities. The facility failed to develop policies and procedures for the use or non use of volunteers during an emergency.	E 024	E024 1. The facility has developed policies and procedures for the use or non-use of volunteers during an emergency. 2. The facility has policies and procedures for use of volunteers during emergency preparedness activities. 3. Facility staff will be educated on: " Policies and procedures for use or non-use of volunteers during an emergency 4. The Administrator will complete a random monthly review of the Emergency Preparedness program to ensure that there are policies and procedures for use or non-use of volunteers during an emergency. 5. Results of the review will be presented to the Quality Assurance	

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E 024	Continued From page 6	E 024	Committee for review and recommendation.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	E 026	E026	6/17/19

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E 026	Continued From page 7 facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the Maintenance Director on 5/8/19 at 11:37 a.m. the Maintenance Director was asked for documentation describing the facilities role in providing care in an alternate care site. The Maintenance Director stated, he did not have any documentation describing the facilities role or the care that would be provided at an alternate care site. The facility staff failed to have documentation describing the facilities role in providing care in an alternate care site.	E 026	1. The facility has included documentation describing the facility□s role in providing care in an alternate care site during an emergency. 2. Provision of care in an alternate site during an emergency is part of the facility Emergency Preparedness Plan. 3. Facility staff will be educated on: " Provision of care at an alternate site during an emergency 4. The Maintenance Director will complete a random weekly review to ensure that staff are aware of the facility□s role in provision of care in an alternate care site during an emergency. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information	E 034		6/17/19

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E 034	Continued From page 8 about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation about the facilities occupancy needs and its ability to provide assistance. The findings included: During an interview on 5/8/19 at 12:06 P.M. with the Maintenance Director, he was asked for documentation for identifying the needs of the facility, including the residents as well as the facilities ability to provide assistance to the Incident Command Center. The Maintenance Director, stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance. The facility staff failed to provide documentation and have means of providing information about	E 034	E034 1. The facility has included documentation of the facility□s occupancy needs and its ability to provide assistance during an emergency. 2. Documentation of the facility□s occupancy needs and its ability to provide assistance during an emergency is included in the facility Emergency Preparedness Plan. 3. Facility staff will be educated on: " Facility occupancy needs and ability to provide assistance during an emergency 4. The Maintenance Director will complete a random weekly review to ensure that staff are aware of the facility occupancy needs and ability to provide assistance during an emergency. 5. Results of the review will be presented to the Quality Assurance	

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E 034	Continued From page 9 the facility's needs and its ability to provide assistance.	E 034	Committee for review and recommendation.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at	E 036		6/17/19

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E 036	Continued From page 10 least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an emergency preparedness training and testing program. The findings included: During an interview on 5/8/19 at 12: 17 p.m. with the Maintenance Director, he was asked for documentation of the facilities training and testing	E 036	E036 1. The facility has a training and testing program for Emergency Preparedness. 2. The facility Emergency Preparedness Plan includes staff training and testing. 3. Facility staff will be educated on: " Emergency Preparedness Plan 4. The Maintenance Director will complete a random weekly review to	

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E 036	Continued From page 11 program. The Maintenance Director stated, the facility had not developed a training and testing program. The facility staff failed to have a training and testing program.	E 036	ensure that staff are trained and tested on the Emergency Preparedness Plan. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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E 037	Continued From page 12	E 037		

hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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E 037	Continued From page 13	E 037		

must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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E 037	Continued From page 14 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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E 037	Continued From page 15 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an initial emergency preparedness training program. The findings included: During an interview on 5/8/19 at 12: 22 P.M. with the Maintenance Director, he was asked for documentation for an Initial Training Program in Emergency Preparedness Policies and Procedures for all new new and existing staff. The Maintenance Director stated, the facility had not conducted an Initial Training Program for Emergency Preparedness. The facility staff failed to have an Initial Emergency Preparedness Training Program.	E 037	E037 1. The facility has completed an initial emergency preparedness training program. 2. The facility has documented completion of the initial emergency preparedness training program. 3. Facility staff will be educated on: " Emergency Preparedness Program 4. The Administrator will complete a random monthly review of documentation of the initial training for the Emergency Preparedness Program. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 000	Continued From page 16 An unannounced Medicare/Medicaid standard survey was conducted 05/07/2019 through 05/09/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three (3) complaints were investigated during this survey. The census is this 180 bed facility was 150 at the time of survey. The survey sample consisted of 55 current Resident reviews and 5 closed record reviews.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 565	Continued From page 17 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Resident Council Meeting, observations and interviews, the facility staff failed to respond to ongoing resident issues. The findings included: The Surveyor received 6 months of resident council meeting minutes from the Activity Director. The following were ongoing concerns for six months: On 12/11/18 Residents complained of (c/o) call bells not being answered. On 11/13/18 Residents c/o cold foods, and call bells not being answered. On 1/08/19 Residents c/o cold foods, and call bells not being answered. On 2/12/19 Residents c/o cold foods, and call bells not being answered. On 3/12/19 call bells not being answered. On 4/9/19 ongoing issues, cold foods, call bells not being answered and not getting snacks. On 05/08/19 at approximately 1:14 PM a Resident Council meeting was held in the	F 565	F565 1. Facility staff respond to resident issues identified during Resident Council Meetings. 2. Facility staff address on-going concerns of call bells not being answered, cold foods, and availability of snacks. 3. Facility staff will be educated on: " Timely answering of call bells " Delivery of food at desired temperature " Availability of snacks " Use of documented service concerns 4. The Administrator will monitor Resident Council Meeting Minutes and Service Concerns to ensure that resident concerns are addressed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 565	Continued From page 18	F 565		

Resident dining room at the facility. There were eleven Resident's present.

An interview was conducted with the residents. The following questions were asked concerning grievances.

1. Does the Grievance Official respond to the resident or the family groups? The response was no.

2. If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response? The response was no.

3. If the Resident Council makes suggestions about some of the rules, does the facility act on those suggestions? The response was no.

A few members stated that once their concerns were addressed
"things will be good for about a week, then the issues would return."
"When we file a grievance they don't do anything."
"We are not being treated like adults."
"Our constitutional rights are being violated."
"My bathroom floor in disrepair x 1 year" "they keep saying we'll fix it."
"Our rights are not respected." "We are not treated equally."

05/08/19 01:38 PM at least 5 residents in resident council meeting. agreed that the food was cold, call bells were not being answered in a timely manner (Sometimes as long as 30 minutes to an hour) and that they were not receiving any snacks unless they asked for them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 565	Continued From page 19	F 565		

On 05/09/19 at approximately, 9:21 AM an interview was conducted with the Social Worker Director. She was asked if the resident council as a whole had filed any grievances with her. She stated there were no grievances on file "but they are fully aware that they can talk with me about any concerns." The surveyors were informed of the above residents concerns. Names were given so that they could follow up with them individually.

On 05/09/19 at approximately 9:32 AM an interview was conducted with the Activities Director concerning the above resident concerns and ongoing resident council minutes. She stated that the concerns are addressed with department heads in morning meetings. She also stated that Resident Rights are discussed at every Resident Council meeting.

Resident Council Policy titled "Activities Policies and Procedures." Effective Date: 04/16/18. The Policy States: The Activities Director will provide patients with support and assistance as designated by the patients in the formation of a Resident Council Meeting. The Procedure States: The Resident Council shall be a patient group meeting regularly to: Discuss and offer suggestions about center policies and procedures affecting patient's care, treatment, and quality of life. New Business states: Open discussion from the floor-concerns/problems/comments. Document council concerns/problems in Resident Council Minutes. Individual concerns should be addressed on the [corporate name] Service Concern report form. Immediately inform the Administrator of any urgent issues, council concerns, or problems."

Various interviews were conducted on 05/09/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 565	Continued From page 20 with the Dietary Director and Director of Nursing (DON) with Resident concerns such as call bell issues, snacks and cold foods. The Dietary Director said that he offers Residents a variety of snacks. Food is warm when it leaves the kitchen. He also said that he will address the resident council with food/snack concerns or a resident with individual concerns. The DON said that she does random call bell audits, encourage team work and address grievances immediately and follow up with resident concerns. 05/09/19 at approximately 03:03 PM an interview was conducted with the administrator and Nurse Consultant concerning the facility having any Plan of Corrections in place for call bells, cold foods and snacks. He stated they have no written Plan of correction. The above findings were shared with the Administrator and Director of Nursing and Nurse Consultant at approximately 5:30 PM during the pre-exit meeting. The administrator stated that snacks should be readily available. The CNA's (Certified Nurses Assistant) can offer snacks to the residents in between meals. "There are some residents that have ordered snacks." per Nurse Consultant.	F 565		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 622	Continued From page 21	F 622		

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.

§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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 622	Continued From page 22	F 622		

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 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 622	Continued From page 23 Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan to include their care plan goals after being discharged/transferred to the hospital for 3 of 60 residents (Resident #52, 51 and 3) in the survey sample. 1. The facility staff failed to send Resident #52's Care Plan Summary to include goals when discharged to the hospital on 03/20/19. 2a. The facility staff failed to convey to the receiving provider Resident #51's comprehensive care plan goals at the time of discharge to the local hospital on 10/11/18. 2b. The facility staff failed to convey to the receiving provider Resident #51's comprehensive care plan goals at the time of discharge to the local hospital on 2/7/19. 3. Facility staff failed to evidence that all the required documentation; care plan goals were sent with the resident at the time of a facility-initiated transfer for Resident #3. The findings included: 1. The facility staff failed to send Resident #52's Care Plan Summary to include goals when discharged to the hospital on 03/20/19. Resident #52 was originally admitted to the facility on 08/31/2001. The resident was readmitted on 03/25/19. Diagnosis for Resident #52 included but not limited to Cardiomyopathy.	F 622	F622 1. Resident #52, #51, and #3 are current residents of the facility. 2. Residents discharged/transferred to the hospital during the past month were reviewed to ensure that a copy of their care plan goals was sent to the receiving provider. 3. Facility staff will be educated on: " Documentation of sending resident care plan goals at time of discharge/transfer to the hospital 4. The Unit Manager will complete a random weekly review of residents who were discharged/transferred to the hospital to ensure that there is documentation that the care plan goals were sent to the receiving provider. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 622	Continued From page 24	F 622		

The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/01/19 coded Resident #52 Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions.

The Discharge MDS assessments dated 03/20/19 - discharge return anticipated, resident readmitted on 03/25/19.

On 03/20/19 at approximately 5:54 a.m., according to the facility's documentation, Resident #52 was observed with thick frothy sputum coming from his nose and mouth, bilateral lungs with noticeable with crackles upon auscultation. Vital signs BP (135/85), P (109), R (20), T (98.4) O2 (91%), on call physician notified with new orders to send to Emergency Room (ER).

An interview was conducted with Unit Manager on (Unit 4) on 05/08/19 at approximately 9:30 a.m. The surveyor asked, "What paperwork is sent with the resident's when they are being transferred out to the hospital." The nurse replied, "Their care plan, transfer summary, medication list and their face sheet." The surveyor asked, "Did Resident #52's care plan go with him upon discharge/transfer to the hospital" she replied, "It should have; there should be a note documented in his chart." On the same day at approximately 9:47 a.m., the Unit Manager said she was unable to locate that Resident #52's care plan was sent with him when discharged to the hospital on 03/20/19.

The Administrator and the Nurse Consultant was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 622	Continued From page 25	F 622		

informed of the finding during a briefing on 05/09/19 at approximately 2:45 p.m. The facility did not present any further information about the findings.

Definition:

*Cardiomyopathy, or heart muscle disease is a type of progressive heart disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood in the lungs or rest of the body (webmd.com).

2a. The facility staff failed to convey to the receiving provider Resident #51's comprehensive care plan goals at the time of discharge to the local hospital on 10/11/18.

2b. The facility staff failed to convey to the receiving provider Resident #51's comprehensive care plan goals at the time of discharge to the local hospital on 2/7/19.

Resident #51 was re-admitted to the nursing facility on 2/18/19 with diagnoses that included traumatic subdural hemorrhage, diabetes, schizophrenia and bipolar disorder.

Resident #51's most recent Minimum Data Set (MDS) assessment dated 2/25/19 coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making.

The nurse's notes dated 10/11/18 indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 622	Continued From page 26	F 622		

resident had a change in condition and was transferred to the Emergency Department (ED). Resident #51 was readmitted on 10/17/18. There was no documentation in the clinical record that facility staff conveyed, to the receiving providers, the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

The nurse's notes dated 2/7/19 indicated that the resident had a change in condition and was transferred to the ED. Resident #51 was readmitted to the nursing facility on 2/18/19. There was no documentation in the clinical record that facility staff conveyed, to the receiving providers, the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

An interview was conducted with the Director of Nursing (DON) on 5/7/19 at 1:08 p.m. She stated the full care plan, SBAR, and transfer form was sent with the resident on transfer from the facility. She stated if not documented they were sent, it was not done.

On 5/9/19 at approximately 4:45 p.m., a debriefing was held with the Administrator, DON and the Nurse Consultant. The the nurse consultant stated that the facility was not sending the care plan summary and goals with the residents upon transfer from the facility and facility wide education would soon take place. No further information was provided prior to survey exit.

3. Facility staff failed to evidence that all the required documentation; care plan goals were sent with the resident at the time of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 622	Continued From page 27	F 622		

facility-initiated transfer for Resident #3.

Resident #3 was admitted to the facility on 6/10/17 and readmitted on 10/20/18 with diagnoses that included but were not limited to type two diabetes, catatonic disorder (1), dementia without behaviors, high blood pressure, and history of convulsions. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/26/19. Resident #3 was coded as being severely impaired in cognitive function on the BIMS (brief interview for mental status) exam.

Review of Resident #3's clinical record revealed that she was sent to the hospital on 2/14/19. The following was documented, "Resident received in bed @ (at) 1115 skin is pale, cold and sweating noted all over her whole body. She was blowing air and saliva out of her mouth and had SOB (Short of breath). Foaming around her whole mouth noted also. She was straining and eye rolling to the back of her head. Her body was stiff, her hands and arms shaking on and off also. Resident is non verbal but is responsive at baseline. Resident was completely non responsive to touch or name. On call physician was called @ 1130 and this nurse left a message but never received call back. 911 called @1135. EMS (emergency medical services) arrives at 1145. Symptoms continued until EMS left with resident. (sic) @1155. Family (sic) contacted @12 pm (sic). Resident transported to (Name of hospital). (VS (vital signs) b/p (blood pressure) 101/61, p. (pulse). 107, 02 (oxygen) 95 % (percent) room air, T(temperature) 97.9, R (respirations) 40.) FSBS (fasting blood sugar) @210."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 622	Continued From page 28	F 622		

Further review of Resident #3's clinical record revealed that she was not admitted to the hospital and arrived back to the facility at 6:45 p.m. The following note was documented: "Resident returned to facility. Awake, alert and oriented x 2-3 and remains non-verbal. Resident is responsive to name and touch VS all within normal limits. Returned to facility with new order for Bactrim (antibiotic) DS (double strength) (2) bid (two times a day) for 3 days for diagnosis of UTI (urinary tract infection). Initial dose given with no s/s (signs/symptoms) of any advance reaction to it..."

Review of Resident #3's "Transfer form" dated 2/14/19 revealed that the following information was sent with Resident #3 upon transfer to the hospital: contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care.

There was no evidence that the care plan goals or the care plan was sent with Resident #3 at the time of transfer.

On 5/9/19 at 1:08 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what documents were sent with a resident at the time of an acute care transfer, ASM #2 stated that nurses should be sending the entire care plan, SBAR (situation, background, assessment and recommendation) sheet and transfer form. When asked if nurses should document what items they had sent with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 622	Continued From page 29	F 622		

resident at the time of transfer, ASM #2 stated, "Yes, because we don't know it was done if it was not documented." ASM #2 then stated that documenting what items were sent was the only way to prove it went with the resident.

On 5/9/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the DON and ASM #3, the nurse consultant were made aware of the above findings.

Facility policy titled, "Discharge Planning Policies and Procedures", did not address the above concern.

No further information was presented prior to exit.

(1) "Catatonia is a clinical syndrome characterized by a distinct constellation of psychomotor disturbances. Two subtypes have been described: Retarded and excited. Catatonia of the retarded type is associated with signs reflecting a paucity of movement, including immobility, staring, mutism, rigidity, withdrawal and refusal to eat...Excited catatonia, on the other hand, is characterized by severe psychomotor agitation, potentially leading to life-threatening complications such as hyperthermia, altered consciousness, and autonomic dysfunction." This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5183991/.

(2) Bactrim DS is a synthetic antibacterial combination product available in DS (double strength) tablets. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/drugs/401/sulfamethoxazo

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 622	Continued From page 30 le---trimethoprim/43/professional.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 623	Continued From page 31	F 623		

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 623	Continued From page 32 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 1 of 60 residents (Resident #52) in the survey sample. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #52's transfer to the hospital on 03/20/19. The findings included: Resident #52 was originally admitted to the facility on 08/31/2001. The resident was readmitted on 03/25/19. Diagnosis for Resident #52 included but not limited to Cardiomyopathy.	F 623	F623 1. The Office for the State Long-Term Care Ombudsman was notified of Resident #52□s transfer to the hospital. 2. Residents discharged/transferred to the hospital over the past month were reviewed to ensure that the Office of the State Long-Term Care Ombudsman was notified at time of discharge/transfer. 3. The Discharge Planners will be educated on: " Documentation of notice of the Office of the State Long-Term Care Ombudsman when resident is discharged/transferred to the hospital 4. The Director of Discharge Planning will complete a weekly review of documentation of the Office of the State	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 33 The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/01/19 coded Resident #52 Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long-term memory problems and with severe cognitive impairment - never/rarely made decisions. The Discharge MDS assessments dated 03/20/19 - discharge return anticipated, resident readmitted on 03/25/19. On 03/20/19 at approximately 5:54 a.m., according to the facility's documentation, Resident #52 was observed with thick frothy sputum coming from his nose and mouth, bilateral lungs with noticeable with crackles upon auscultation. Vital signs BP (135/85), P (109), R (20), T (98.4) O2 (91%), on call physician notified with new orders to send to Emergency Room (ER). Review of Resident #52's medical record does not contain evidence that the notice was sent to the Ombudsman. An interview was conducted with the Social Worker (SW) on 05/07/19 at approximately 2:55 p.m. The SW was asked, "Who is responsible for notifying the Ombudsman when a resident is being transferred/discharged to the hospital" she replied, "Me." The surveyor requested documentation to show the Ombudsman was notified of Resident #52's discharge to the hospital on 03/20/19. On the same day at approximately 3:10 p.m., the SW said she was unable to locate documentation to provide the ombudsman was notified of Resident #52's discharge to the hospital on 03/20/19. The Administrator and the Nurse Consultant was	F 623	Long-Term Care Ombudsman when a resident is discharged/transferred to the hospital. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 623	Continued From page 34 informed of the finding during a briefing on 05/09/19 at approximately 2:45 p.m. The facility did not present any further information about the findings. Definition *Cardiomyopathy, or heart muscle disease is a type of progressive heart disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood in the lungs or rest of the body (webmd.com).	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 625	Continued From page 35 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed send a copy of the Bed-Hold Policy for 5 of 60 residents (Resident #52, 79, 51, 55 and 3) after being transferred to and admitted to the hospital. 1. The facility staff failed to ensure that Resident #52 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 03/20/19. 2. The facility failed to provide Resident #79 with a written notice of the facility's Bed-Hold Policy upon transfer to the hospital 4/17/19. 3. The facility staff failed to ensure Resident #51 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 10/11/18 and 2/7/19. 4. The facility staff failed to ensure that Resident #55 received a written notice of the facility Bed-Hold policy upon transfer to the hospital on 02/19/19. 5. For Resident #3, facility staff failed to evidence that written bed hold notification was provided to the resident/responsible party at the time of a	F 625	F625 1. Resident #52, #79, #51, #55, and #3 are current residents of the facility. 2. Residents discharged/transferred to the hospital over the past month were reviewed to ensure that a copy of the facility bed-hold and reserve bed payment policy was provided at time of discharge/transfer. 3. Charge Nurses will be educated on: " Sending copy of facility bed-hold and reserve bed payment policy at time of discharge/transfer to the hospital " Documentation that copy of facility bed-hold and reserved bed payment policy at time of discharge/transfer to the hospital was provided to the Resident 4. The Unit Managers will complete a random weekly review of residents discharged/transferred to the hospital to ensure that there is documentation that the written bed-hold and reserve bed payment policy was sent with the Resident. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 36	F 625		

facility initiated transfer to the hospital on 2/14/19.

The findings included:

1. The facility staff failed to ensure that Resident #52 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 03/20/19.

Resident #52 was originally admitted to the facility on 08/31/2001. The resident was readmitted on 03/25/19. Diagnosis for Resident #52 included but not limited to Cardiomyopathy.

The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/01/19 coded Resident #52 Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions.

The Discharge MDS assessments dated 03/20/19 - discharge return anticipated, resident readmitted on 03/25/19.

On 03/20/19 at approximately 5:54 a.m., according to the facility's documentation, Resident #52 was observed with thick frothy sputum coming from his nose and mouth, bilateral lungs with noticeable with crackles upon auscultation. Vital signs BP (135/85), P (109), R (20), T (98.4) O2 (91%), on call physician notified with new orders to send to Emergency Room (ER).

An interview was conducted with Unit Manager on (Unit 4) on 05/08/19 at approximately 9:30 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 37	F 625		

The surveyor asked, "What paperwork is sent with the resident when they are being transferred out to the hospital." The nurse replied, "Their care plan, transfer summary, medication list and their face sheet." The surveyor asked, "Do you send the bed hold policy at the time of discharge?" The Unit Manager stated, "I have never sent the bed hold policy." She said all paperwork sent with the resident at the time or discharge should be documented in the resident's medical record. On the same day at approximately 9:47 a.m., the Unit Manager said she was unable to locate documentation in the resident's chart to indicate Resident #52 was ever given a copy of the bed hold policy at the time of his discharge to the hospital.

The Administrator and the Nurse Consultant was informed of the finding during a briefing on 05/09/19 at approximately 2:45 p.m. The facility did not present any further information about the findings.

Definition

*Cardiomyopathy, or heart muscle disease is a type of progressive heart disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood in the lungs or rest of the body (webmd.com).

2. The facility failed to provide Resident #79 with a written notice of the facility's Bed-Hold Policy upon transfer to the hospital 4/17/19.

Resident #79 was originally admitted to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 38	F 625		

10/11/13, and was readmitted to the facility 4/22/19, after an acute care hospital stay. The current diagnoses included; stroke with left hemiparesis, and seizure disorder.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/23/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #79's daily decision making abilities were intact.

In section "G" (Physical functioning) the resident was coded as requiring total care of one with bathing, extensive assistance of one with bed mobility, transfers, dressing, personal hygiene, toileting and independent after set-up with locomotion.

Review of the discharge MDS assessment dated 4/17/19, revealed Resident #79 was discharged - return not anticipated.

Review of the clinical record revealed a nurse's note dated 4/17/19, at 14:44 p.m., which stated Resident #79 was follow-up assessment stated the resident "began to have tremors, eyes rolled in the back of her head. Facial drooping, left arm weakness, and difficulty speaking. The provider gave orders to send the resident to the emergency department for possible stroke, to evaluate and treat. A call was placed to the emergency department and report was given. 911 rescue called to transport. Resident left the facility at 14:45. The resident's vital signs are as follows: blood pressure 122/62, pulse oximetry reading 96% on room air, heart rate 86 deep sleep and blood sugar 128".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 39	F 625		

On 5/9/19 at approximately 11:45 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated the written Bed-hold notice wasn't given to the resident and/or resident representative at the time of her transfer to the hospital 4/17/19.

The Administrator and the Nurse Consultant was informed of the finding during a briefing on 05/09/19 at approximately 2:45 p.m. The facility did not present any further information about the findings.

3. The facility staff failed to ensure Resident #51 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 10/11/18 and 2/7/19.

Resident #51 was re-admitted to the nursing facility on 2/18/19 with diagnoses that included traumatic subdural hemorrhage, diabetes, schizophrenia and bipolar disorder.

Resident #51's most recent Minimum Data Set (MDS) assessment dated 2/25/19 coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making.

The nurse's notes dated 10/11/18 indicated the resident had a change in condition and was transferred to the Emergency Department (ED). Resident #51 was readmitted on 10/17/18. There was no documentation in the clinical record that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 40	F 625		

the bed hold notice was issued to the resident or RR at the time of any of the transfers or discharges.

The nurse's notes dated 2/7/19 indicated that the resident had a change in condition and was transferred to the ED. Resident #51 was readmitted to the nursing facility on 2/18/19. There was no documentation in the clinical record that the bed hold notice was issued to the resident or RR at the time of any of the transfers or discharges.

An interview was conducted with the Director of Nursing (DON) on 5/7/19 at 1:08 p.m. She stated that nursing did not issue the bed hold notice at the time of discharge and was not sure if the social worker or the admissions office issued the notice.

On 5/9/19 at approximately 4:45 p.m., a debriefing was held with the Administrator, DON and the Nurse Consultant. The the nurse consultant stated the bed hold notice was not giving to the resident or RR at the time of discharge from the facility and that facility wide education would soon take place. No further information was provided prior to survey exit.

4. The facility staff failed to ensure that Resident #55 received a written notice of the facility Bed-Hold policy upon transfer to the hospital on 02/19/19.

Resident #55 was admitted to the facility on 12/12/18 and readmitted to the facility on 02/28/19. Diagnosis for Resident #55 included but not limited to Pressure Ulcer of Unspecified,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 41	F 625		

Pressure Ulcer of Right Hip, and Major Depressive Disorder.

The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 02/19/19. Staff assessment of mental status coded the resident as having short term memory problems.

The Discharge MDS assessments was dated for 02/19/19 - discharge return anticipated; re-admitted to the facility on 02/28/19.

On 02/19/2019, according to the facility's documentation, Resident #55 was transferred to the local hospital ER from his appointment at the wound clinic. (RP) Responsible Party was called but was with Resident #55 at the time of transfer.

An interview was conducted on 05/07/19 at approximately, 1:41 PM with the Admissions Coordinator (Other Staff #5). He was asked if a bed hold had been issued on Resident #55 during his transfer to the hospital on 02/19/19. The Admissions Coordinator stated "Our standard practice for LTC (Long Term Care) is that we always hold the bed for them".

On 05/07/19 at approximately, 2:02 PM an interview was conducted with the Social Work Director (Other Staff #1) concerning the issuance of the bed hold policy. She stated that admissions issues the bed hold policy.

An interview was conducted with License Practical Nurse (LPN) #4 on 05/08/19 at approximately 10:15 AM, concerning the above information. She stated, "We don't do the bed holds from the unit". "I'm not sure who to refer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 42	F 625		

you too."

On 05/09/19 at approximately 1:42 PM an interview was conducted with the Director of Nursing concerning the above information. She stated that there were no bed holds put in place.

On 05/09/19 at approximately 5:29 PM an interview was conducted with the Administrator, Director of Nursing and Nurse Consultant they were informed of the above findings. They were asked what should have been done concerning Resident #55's bed hold notification? The administrator stated that we will have nursing issue the bed hold and notify the family.

5. For Resident #3, facility staff failed to evidence that written bed hold notification was provided to the resident/responsible party at the time of a facility initiated transfer to the hospital on 2/14/19.

Resident #3 was admitted to the facility on 6/10/17 and readmitted on 10/20/18 with diagnoses that included but were not limited to type two diabetes, catatonic disorder (1), dementia without behaviors, high blood pressure, and history of convulsions. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/26/19. Resident #3 was coded as being severely impaired in cognitive function on the BIMS (brief interview for mental status) exam.

Review of Resident #3's clinical record revealed that she was sent to the hospital on 2/14/19. The following was documented, "Resident received in bed @ (at) 1115 skin is pale, cold and sweating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 43	F 625		

noted all over her whole body. She was blowing air and saliva out of her mouth and had SOB (Short of breath). Foaming around her whole mouth noted also. She was straining and eye rolling to the back of her head. Her body was stiff, her hands and arms shaking on and off also. Resident is non verbal but is responsive at baseline. Resident was completely non responsive to touch or name. On call physician was called @ 1130 and this nurse left a message but never received call back. 911 called @1135. EMS (emergency medical services) arrives at 1145. Symptoms continued until EMS left with resident. (sic) @1155. Family (sic) contacted @12 pm (sic). Resident transported to (Name of hospital). (VS (vital signs) b/p (blood pressure) 101/61, p. (pulse). 107, 02 (oxygen) 95 % (percent) room air, T(temperature) 97.9, R (respirations) 40.) FSBS (fasting blood sugar) @210."

Further review of Resident #3's clinical record revealed that she was not admitted to the hospital and arrived back to the facility at 6:45 p.m. The following note was documented: "Resident returned to facility. Awake, alert and oriented x 2-3 and remains non-verbal. Resident is responsive to name and touch VS all within normal limits. Returned to facility with new order for Bactrim (antibiotic) DS (double strength) (1) bid (two times a day) for 3 days for diagnosis of UTI (urinary tract infection). Initial dose given with no s/s (signs/symptoms) of any advance reaction to it..."

Review of Resident #3's clinical record failed to evidence that the bed hold policy was sent with the resident at the time of transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 44	F 625		

On 5/9/19 at 1:08 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what documents were sent with a resident at the time of an acute care transfer, ASM #2 stated that nurses should be sending the entire care plan, SBAR (situation, background, assessment and recommendation) sheet and transfer form. When asked if nurses should document what items they had sent with the resident at the time of transfer, ASM #2 stated, "Yes, because we don't know it was done if it was not documented." ASM #2 then stated that documenting what items were sent was the only way to prove it went with the resident. When asked if nurses sent the bed hold policy with the resident at the time of transfer, ASM #2 stated that the nurses do not send the bed hold. ASM #2 stated that she thought that social work and admissions shared that responsibility.

On 5/9/19 at 2:19 p.m., an interview was conducted with OSM (other staff member) #5, admissions. When asked his role when a resident is sent to the hospital for an acute change in condition, OSM #5 stated that he will follow up with the resident and/or family member and offer a bed hold. OSM #5 stated that the admission director will also go to the hospital to reach out to the family. When asked if the bed hold policy was sent with the resident at the time of transfer, OSM #5 stated, "It will be going forward."

On 5/9/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the DON and ASM #3, the nurse consultant were made aware of the above findings.

Facility policy titled, "Bed Reserve," documents in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 45	F 625		

part, the following: " Medicaid and Medicare programs do not pay to hold beds in the Health and Rehabilitation Center when a patient is hospitalized overnight. Consequently, whenever any patient (regardless of payer source) is transferred from the Health and Rehabilitation Center and is admitted for overnight hospitalization/observation (defined as being absent from the Health and Rehabilitation Center for more than 25 hours), the patient and or the responsible representative must pay to hold the bed if the patient wished to ensure that he/she can return to the bed he/she is occupying...To make this arrangement the patient and/or responsible representative must (1) promptly complete and sign a formal "Voluntary Bed Retention Agreement" and (2) provide private payment to the Health & Rehabilitation Center for the requested days. This arrangement can be made at the time of transfer, or by the close of the business day on which the hospitalization occurs, but no later than 10:00 a.m. on the day following the hospitalization."

No further information was presented prior to exit.

(1) "Catatonia is a clinical syndrome characterized by a distinct constellation of psychomotor disturbances. Two subtypes have been described: Retarded and excited. Catatonia of the retarded type is associated with signs reflecting a paucity of movement, including immobility, staring, mutism, rigidity, withdrawal and refusal to eat...Excited catatonia, on the other hand, is characterized by severe psychomotor agitation, potentially leading to life-threatening complications such as hyperthermia, altered consciousness, and autonomic dysfunction." This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 625	Continued From page 46 information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5183991/. (2) Bactrim DS is a synthetic antibacterial combination product available in DS (double strength) tablets. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/drugs/401/sulfamethoxazole---trimethoprim/43/professional.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 interviews, and review of the facility's policy the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 60 residents (Resident #92), in the survey sample. The facility staff failed to code hearing and vision loss in section "B0200 and "B1000" and hospice services in section "O0100K2" of Resident #92's 4/1/19 quarterly MDS assessment. The findings included; Resident #92 was admitted to the facility 12/1/15 and was discharged from the facility to a local acute care hospital 6/22/18 and returned 6/25/18. The current diagnoses include; legal blindness, bilateral hearing loss and dementia.	F 641	F641 1. Resident #92□s MDS was modified on 5/9/19 to include hearing and vision loss and hospice services. 2. Residents with hearing loss and receiving hospice services were reviewed to ensure that the most recent MDS was coded accurately. 3. MDS coordinators will be educated on: " Accurate coding of vision and hearing loss " Accurate coding of hospice services 4. The DON/ADON will complete a random weekly review of MDS to ensure that coding of hearing and vision loss and hospice services are coded accurately on the MDS. 5. Results of the review will be	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 641	Continued From page 47 The quarterly MDS assessment with an assessment reference date (ARD) of 4/1/19 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. The facility's policy titled "Minimum Data Assessment" dated 9/15/16 read; at #7. Each person entering data into the MDS will date the MDS on the MDS signature page indicating the sections/questions each completed attesting to accuracy of the sections they completed. #8 read; By signing, staff indicate their knowledge that accuracy of the MDS is essential because that information is used to generate payment for medicare patients and data for Quality Indicators and Quality Measures as well as impacting the facility's Medicaid rate. In section "B0200" was coded for adequate hearing - no difficulty in normal conversation, social interaction or listening to television. Section "B1000" was coded adequate vision - sees fine detail, including regular print in newspapers and books. In section "O" no special treatments or programs were coded, although the resident had been receiving Hospice services since 6/27/18. Resident #92 was observed in bed 5/8/19 at approximately 10:50 a.m. The resident didn't respond in any manner after multiple knocks at the door and asking if the surveyor could enter the room. Upon nearing the resident bed a sign was observed on the wall stating the resident was hearing and visually impaired. Resident #92's undated care plan had a problem	F 641	presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 641	Continued From page 48	F 641		

which read; the resident has a communication problem related to a hearing deficit/deafness. The goal read; the resident will be able to make basic needs known on a daily basis through the next review date. The interventions included; anticipate and meet needs and refer to audiology for a hearing consult as ordered. Another care plan problem read; the resident has an activities of daily living (ADL) self-care performance deficit related to dementia, legal blindness as defined in the United States of America and deafness. The goal read; the resident will maintain current function through the review date. The interventions included; devices: perimeter mattress, low bed with mats, geri-chair, and grab bars times two.

An interview was conducted with certified nursing assistant (CNA) #1 on 5/9/19 at approximately 9:55 a.m. CNA #1 stated he was assigned to care for the resident and he was very familiar with Resident #92. CNA #1 stated the resident is with poor vision and has a hearing loss therefore; in order to assure the resident knows someone was present they gently touch her hand prior to rendering any care. CNA #1 also stated he was aware the resident received hospice services because he often sees the hospice nurse in her room and this day the hospice nurse fed the resident her breakfast.

An interview was conducted with the MDS Coordinator 5/9/19 at approximately 10:10 a.m. The MDS Coordinator reviewed the hearing, vision and hospice sections of Resident #92's 4/1/19 quarterly MDS assessment and stated they were coded incorrectly. At approximately 1:00 p.m., the MDS Coordinator presented a modified 4/1/19 MDS assessment due to item

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 641	Continued From page 49 coding errors and data entry errors. The modified MDS assessment coded Resident #92 with highly impaired hearing, severely impaired vision and for receiving hospice services. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Director of Nursing stated she would have to view the 4/1/19, MDS assessment herself to determine if it was not coded accurately but it was her understanding the MDS had been corrected.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 655	Continued From page 50 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview and facility document review, the facility staff failed to ensure the baseline care plan summary was provided for 1 out of 60 residents (Resident #453) in the survey sample. The facility staff failed to issue a newly admitted resident, (Resident #453), a copy of the care plan summary. The summary must include the initial goals for the resident, a list of current medications and dietary instructions and services and treatments to be administered by the facility. The findings included: Resident #453 was admitted to the nursing facility on 05/03/19. Resident #453 diagnosis included	F 655	F655 1. Resident #453 and representative were provided a copy of the care plan summary which included the initial goals for the resident. A list of current medications and dietary instructions and services and treatments to be administered by the facility. 2. Residents admitted within the past month were reviewed to ensure that the Resident and their representative were given a copy of the baseline care plan. 3. Charge Nurses will be educated on: " Development of the baseline care plan within 48 hours of admission " Inclusion of initial goals for the resident, list of current medications,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 655	Continued From page 51 but not limited to Pulmonary Fibrosis, hypoxia, Anxiety and Congestive Heart Failure. The resident's Minimum Data Set (MDS) assessment was not due. During the initial on 05/07/19 at approximately 12:07 p.m. Resident #453 was asked if she received a written care plan summary and if so did anyone explain the summary to her. She said as far as I know, no one has given me anything. The resident stated, "I came here from the hospital but no one has really told me what I "supposed to do now." The review of Resident #453's Admission Order dated May 03, 2019 included but not limited to the following medications, dietary instructions and treatment: Medications include but not limited to: -Ativan tablet 0.5 mg - give 0.5 mg by mouth every 6 hours as needed for anxiety for 14 days. -Ventolin HFA - give 2 puffs inhale orally every 6 hours as needed for shortness of breath. -Meclizine - give 25 mg by mouth every 6 hours as needed for dizziness. Dietary instructions: -Regular diet - Level (7) - regular texture and regular liquid consistency. -Ensure Plus - one time a day 237 ml at med pass (no chocolate). Treatment include but not limited to: -Oxygen therapy -oxygen at (specify) liters per minute via nasal cannula every shift. -Geriatric Psych Consult as needed with a start date of 05/06/19.	F 655	dietary instructions, services and treatments to be administered by the facility " Documentation that the baseline care plan was provided to the Resident and representative 4. The Unit Managers will complete a random weekly review of documentation that the baseline care plan was provided to the Resident and representative. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 655	Continued From page 52	F 655		

An interview was conducted with the Administrator and Nurse Consultant on 05/09/19 at approximately 2:45 p.m. The surveyor asked if Resident #453 received her baseline care plan to include but not limited to the following: Their initials goals, medication list, and how her care and services to be provided. The Nurse Consultant stated, "We started the initial education for the issuing of the care plan summary but that is as far as we have gotten. She said as of right now, the care plan summary is not being done at this time."

The facility's policy titled Care Planning (Revision date: 11/28/17).

Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.

Procedure:
1. The computerized baseline Care Plan is initiated and activated within 48 hours.
2. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes, but is not limited to:
-The initials goals
-A summary of the patient's medication list
-The patients' dietary instructions
-Any services and treatments to be administered by the Center and personnel acting on behalf of the Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 655	Continued From page 53 Definitions: *Pulmonary fibrosis is a lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it more difficult for your lungs to work properly (http://www.mayoclinic.org). *Hypoxia - diminished availability of oxygen to the body tissues (Reference: http://medical-dictionary.thefreedictionary.com/hypoxia) *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). *Congestive Heart Failure is a condition in which the heart can not pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 54 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 656	F656	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 55 interview, clinical record review and facility document review, it was determined that facility staff failed to implement the comprehensive care plan for one of 60 residents in the survey sample, Resident #31. Facility staff failed to implement the comprehensive care plan and ensure Resident #31's environment was free from fall hazards. The findings include: Resident #31 was admitted to the facility on 8/5/18 with diagnoses that included but were not limited to Parkinson's disease (1), schizophrenia, and muscle weakness. Resident #31's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/22/19. Resident #31 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #31 was coded in section G (Functional Status) as being able to walk independently in his room. On 5/9/19 at 10:00 a.m., an observation was made of Resident #31's bathroom. The vinyl flooring was torn in several places with loose debris across the floor. The writer had loose vinyl debris stuck underneath shoes during this observation. Resident #31 could not be reached for an interview at this time. On 5/9/19 at 10:00 a.m., Resident #31's roommate (Resident #124), saw this writer look at the bathroom and stated that he was the one who alerted maintenance about the bathroom. Resident #124 stated that he had talked to	F 656	1. Resident #31□s care plan intervention to ensure that the environment is free from fall hazards is being implemented. 2. Resident fall care plans were reviewed to ensure that interventions are identified for fall prevention. The environment was reviewed to ensure that the environment is free from fall hazards. 3. Facility staff will be educated on: " Communication of fall hazards to Maintenance " Identification of fall hazards in the environment Charge Nurses will be educated on: " Care plan goals for fall prevention 4. The Administrator will complete a random weekly review of the Resident environment to ensure that the environment is free from fall hazards. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 56	F 656		

maintenance three weeks ago regarding the floor and that maintenance was in the process of getting new material. Resident #124 stated that maintenance gave him an estimated time frame of two weeks before the new flooring would come in but now that timeframe was pushed back a week. Resident #124 stated that he does not get caught up in the floor because he uses his wheelchair to propel in the bathroom and transfer when he reaches the toilet. Resident #124 stated that he could not walk. Resident #124 stated that the floor started to fall apart a year ago but that it just recently got really bad.

Review of Resident #31's clinical record revealed that he was a fall risk and has had several falls with no injury while at the facility. Resident #31's most recent falls were on 3/15/19, 2/7/19 and 12/8/18. The following was documented on the post fall assessment for all three falls: "Problems with mobility: unsteady gait/poor balance" and "history of falls."

The most recent fall dated 3/15/19 was in the resident's bathroom. The following was documented: "Resident found in his bathroom, on his knees attempting to get off floor. I asked resident, "did (sic) you fall?" resident (sic) stated, "Yes I am fine." I asked resident "What were you trying to do" (sic) Resident stated I was trying to use the bathroom, (sic) resident educated. assessment (sic) completed. skin (sic) intact. Neuro checks in place. pa (physicians assistant) notified. resident (sic) is own RP (responsible party). call (sic) bell in reach. will (sic) continue to monitor." There was no evidence that Resident #31's fall was related to the flooring.

Review of Resident #31's fall risk assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 57	F 656		

dated 3/20/19 documented the following: "Tries to stand, transfer, or walk alone independently."

Review of Resident #31's fall care plan dated 8/15/18 and revised 3/15/18 documented the following: "The resident is at risk for falls r/t (related to) limited physical mobility...The resident will be free from falls through next review date. Goals/Interventions: Anticipate and meet The resident's needs...Assistive Devices: rollator, wheelchair with cushion, neck brace, bed extender. Be sure residents call light is within reach and encourage the resident to use it. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Keep environment free of hazards."

On 5/9/19 at 12:55 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked if Resident #31 could ambulate by himself, ASM #2 stated that it was unsafe for him to ambulate on his own and that he needed supervision. ASM #2 stated that he was discouraged to walk independently. ASM#2 stated that he sometimes walks without assistance and takes himself to the bathroom. ASM #2 stated that Resident #31 has had falls in the past and that his diagnosis of Parkinson's Disease made him unsteady on his feet and a fall risk. When asked if she had been his bathroom recently, ASM #2 stated that she had not. ASM #2 stated that she knew repairs would start soon to his bathroom. This writer asked ASM #2 to view the bathroom with this writer.

On 5/9/19 at 1:09 p.m., observation was made of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 58	F 656		

Resident #31's bathroom with ASM #2. At that time Resident #31 was observed coming out of the bathroom by himself in his wheelchair. When asked ASM#2 if his bathroom was a trip hazard, ASM #2 stated, "Oh yes, it can be." When asked what could be done in the meantime while maintenance is working to get materials for the floor, ASM#2 stated that the floor could be stripped to the base floor so that there were no loose particles. ASM #2 stated that she wasn't sure how long the bathroom was in disrepair. ASM #2 stated that she hadn't seen the floor that bad until that observation with this writer. ASM #2 stated that she believed the floor was previously tile and that it was all torn up because maintenance may have removed the tile and began work. ASM #2 stated that all the bathroom floors on that hallway were tile.

On 5/9/19 at 1:11 p.m., observations were made of several bathrooms on the 300 hall. The following rooms were observed: 319, 323, 326, 321. All rooms had vinyl flooring to the bathrooms, not tile.

Review of maintenance's work orders from the past three months revealed that a work order had not been submitted for the bathroom floor.

On 5/9/19 at 2:22 p.m., an interview was conducted with OSM (other staff member) #2, the Director of Maintenance. When asked how he was made aware that repairs were needed in Resident's rooms and/or bathrooms, OSM #2 stated that any staff member could alert him or submit a work order. OSM #2 stated that he also does room rounding on every room at least once per week. OSM #2 stated that Resident #31's roommate had alerted him about the bathroom in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 59	F 656		

early April and that the week prior (In March) he only noticed floor discoloration. OSM #2 stated that there was no work order submitted for Resident #31's bathroom, that he was only alerted by Resident #31's roommate. OSM #2 stated that since the floor has been falling apart, he has been trying to get new material to fix the floor. When asked what material the floor was made out of in Resident #31's bathroom, OSM #2 stated that it was vinyl. When asked if the material in the bathroom was a hazard for a resident who can ambulate in the bathroom, OSM #2 stated, "It could be." When asked what could be done to fix the hazard while he was waiting for the new material to come in, OSM #2 stated that he could remove any loose pieces or debris on the floor. When asked how it gets communicated to other departments including nursing, that he is waiting on material to fix the floor, OSM #2 stated that he will send emails out to every department. OSM #2 stated that it did not get communicated to nursing that he was waiting on material to fix the floor.

On 5/9/19 at 2:35 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #31's nurse. When asked the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to serve as a guide that specifically addressed needs, care for a particular resident. When asked if it was important for the care plan to be followed, LPN #2 stated that it was. When asked if Resident #31 was a fall risk, LPN #2 stated that he was a fall risk due to him being unsteady and shaky from his Parkinson's disease. When asked if Resident #31 tries to ambulate on his own without assistance, LPN #2 stated that he did. When asked what was going on with his bathroom floor, LPN #2 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 60	F 656		

maintenance was working on it but was not sure how long his floor was in disrepair. When asked if his current floor could possible be fall hazard for Resident #31, LPN #2 stated that it could. When asked what could be done in the meantime to prevent falls, LPN #2 stated that staff could offer him a bedside commode, pull debris from the floor or offer and move the resident to another room. When asked if these things were done, LPN #2 stated, "I am not sure." LPN #2 stated that Resident #31 mostly propelled in his wheelchair. When asked if it was also possible for him to trip on the bathroom floor while transferring from is wheelchair to the toilet in the bathroom, LPN #2 stated that it was. When asked if his fall care plan was being followed, LPN #2 stated, "No, not at the moment."

On 5/9/19 at 3:30 p.m., an interview was attempted with Resident #31. Resident #31 stated that he did not have time to answer questions because he was getting ready to go shower. Resident #31 stated if he had time, he would try to find this writer later.

On 5/9/19 at approximately 4 p.m., OSM #2 presented his room rounding/inspection from March 2019. There was no evidence that Resident #31's bathroom floor was in disrepair until early April 2019. The following emails were written between OSM #2 and the company used to obtain the materials:

"April 02, 2019
Goid (sic) afternoon (name of OSM #2). It was nice meeting with you yesterday. Here are the pictures (pictures of a floor) we had talked about. Let me know what you think.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 656	Continued From page 61	F 656		

April 19th, 2019 (From OSM #2)
What do you think of this type of flooring. This is being installed in other [corporate name] building.

April 19th 2019 (From company)
Looks great!

April 19th 2019 (From OSM #2)
(Name of representative at company),
Sorry for the delay, however I need you here ASAP to get those two bathrooms floor completed. Please respond ASAP.

April 19th 2019 (From company)
Yes sir. I will call you later and work out the details.

April 22, 2019 (From OSM #2)
(Name of representative at company),
I really need to get the ball rolling on the two bathrooms at my facility. I mean fast."

On 5/9/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) and ASM #3, the nurse consultant were made aware of the above concerns.

Facility policy titled, "Care Planning," documented in part, the following: "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient."

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and review of the facility's policy the facility staff failed to assure the person centered plan of care was revised as the resident's status changed for 1 of 60 residents, (Resident #79) in the survey sample. The facility staff failed to revise Resident #79's	F 657	F657 1. Resident #79□s care plan was revised to reduce the likelihood of another fall. 2. Residents with falls were reviewed to ensure that interventions are in place to reduce the likelihood of another fall. 3. Charge Nurses will be educated on:	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 657	Continued From page 63 care plan after a fall to reduce the likelihood of another fall. The findings included; Resident #79 was originally admitted to the facility 10/11/13, and was readmitted to the facility 4/22/19, after an acute care hospital stay. The current diagnoses included; stroke with left hemiparesis, and seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/23/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #79's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one with bathing, extensive assistance of one with bed mobility, transfers, dressing, personal hygiene, toileting and independent after set-up with locomotion. An interview was conducted with Resident #79 on 5/8/19 at approximately 10:43 a.m. The resident stated about a week ago she was outside with activity staff and the activity staff was propelling her in her wheel chair. The resident stated her left leg was resting on a foot rest because it is her weak leg and she was holding the right leg up by lifting it, then suddenly the right leg made contact with the pavement causing the wheel chair to come to a sudden stop and project her out of the wheel chair on to the pavement. Resident #79 stated she sustained no injuries but it was a frightening incident.	F 657	" Revision of the care plan to reduce the likelihood of another fall 4. The DON will complete a weekly review of care plans for residents who fell to ensure that the care plan was revised to include interventions to reduce the likelihood of another fall. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 657	Continued From page 64	F 657		

An interview was conducted with the Activity assistant on 5/9/19 at approximately 11:00 a.m. The Activity assistant stated she was propelling Resident #79 outside, the paralyzed leg was up, the other leg was down and when they got to the slant in the sidewalk the resident's down foot hit the concrete and the resident fell from the wheel chair and rolled over on her side on the ground. The Activity assistant stated she and another staff member put the resident back in her wheelchair and took her upstairs so the nurse could assess the resident. The Activity assistant stated on the day Resident #79 fell; her supervisor educated her that if a resident doesn't have leg rest on the wheel chair the resident can't be pushed.

Review of the nurse's notes revealed a note dated 4/23/19 at 12:50, which stated fall without injury.

On 4/23/19 at 16:46, an order was obtained for an x-ray of the left lower foot and ankle related to pain post fall. The x-ray results dated 4/24/19, revealed no acute fracture or dislocation.

A facility Fall Risk Assessment was completed for Resident #79 on 4/23/19. The only risk identified were use of diuretics, anti-hypertensives, anti-seizure and antidepressant medications as well as chair bound and requires assistance with toileting.

Resident #79's care plan had an undated problem which read; the resident is at risk for falls related to deconditioning. The goals read; the resident will be free of falls through the next review date, the resident will be free of minor injury through the review date, and the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 657	Continued From page 65	F 657		

will not sustain serious injury through the review date. The interventions included; anticipate and meet the resident's needs. Keep the environment free of trip hazards. Be sure the resident's call light is within reach and encourage the resident to use it. Remind resident to rise slowly to prevent orthostatic hypotension. Grab bar x2, wheel chair with cushion, left foot orthotic, anti-tippers.

Resident #79's care plan did not have the intervention, do not propel the resident's wheel chair without leg rest in place, prior to the 4/23/19, fall neither after the fall. The intervention was added 5/9/19.

The facility staff reviewed Resident #79's fall during the fall committee meeting on 4/26/19. The notes stated; improper use/handling of the resident in a wheel chair. The intervention was to educate the staff on not pushing the resident in the wheel chair without foot rest.

MDS Coordinator #1 stated the fall intervention was linked to the care plan but when the care plan was viewed in the electronic system or printed the intervention was not viewable. MDS Coordinator #1 presented a care plan with the added interventions on 5/9/19 at approximately 4:20 p.m.

The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Corporate Consultant stated Resident #79's fall intervention was linked to the care plan.

The facility's policy titled "Care Planning" dated 11/28/16 read; under procedure 4: Computerized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 657	Continued From page 66 care plans will be updated by each discipline on an ongoing basis as changes in the resident occur, and reviewed quarterly with the quarterly assessment. procedure 8 read; a licensed nurse will review the care plan with the staff on his/her unit to ensure that care is rendered as outlined on the care plan.	F 657		
F 658 SS=D	Complaint Deficiency 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 clinical record review, staff interviews, and review of the facility's policy the facility staff failed to provide care and services to maintain the resident's highest physical well-being for 1 of 60 residents (Resident #92), in the survey sample. The facility staff failed to follow the physician's order dated 6/29/18 and the person centered-care plan for, no weights for Resident #92. The findings included: Resident #92 was admitted to the facility 12/1/15 and was discharged from the facility to a local acute care hospital 6/22/18 and returned 6/25/18. The current diagnoses include; legal blindness, bilateral hearing loss and dementia.	F 658	F658 1. Resident #92□s physician orders and person-centered care plan are being followed. 2. Residents with orders for no weights were reviewed to ensure that the physician order and person-centered care plan is being followed. 3. Charge Nurses will be educated on: " Refraining from obtaining weights as ordered 4. The Unit Managers will complete a random weekly review of Residents with orders to discontinue weights to ensure that the physician order and person-centered care plan is followed. 5. Results of the review will be presented to the Quality Assurance Committee for review and	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 658	Continued From page 67	F 658		

The quarterly MDS assessment with an assessment reference date (ARD) of 4/1/19 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 total care with bathing, personal hygiene, and toilet use, extensive assistance with eating, dressing and bed mobility.

Review of the May 2019 physician's order summary revealed an order dated 6/29/18 which read; other treatment restrictions; do not resuscitate (DNR), no weights, and Hospice care.

Review of the undated care plan revealed a problem which read; the resident has a terminal prognosis, do not resuscitate, no hospitalizations and no weights. The goal read; the resident's comfort will be maintained through the review date. The interventions included; assist resident with coping strategies and respect resident wishes, observe resident closely for signs of pain, administer pain medications as ordered and notify the physician immediately if there is breakthrough pain.

Review of Resident #92's "Weights and Vital Summary" revealed the following recorded weights; 1/4/19 102 pounds, 2/6/19 103.5 pounds, 4/2/19 103 pounds, 5/2/19, 99.5 pounds.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 5/9/19 at approximately 1:30 p.m. LPN #1 stated the resident had a physician's order dated 6/29/18,

recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 658	Continued From page 68 not to obtain weights and nothing had changed by the physician, resident representative or the interdisciplinary team therefore; the weights should have not been obtained. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Director of Nursing stated she couldn't state if Resident #92's comfort was compromised by moving her to obtain weights but because there was a physician's order not to obtain weights the staff should have not obtained them.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to provide fingernail care for Resident #74, prior to his fingernails becoming long and with broken sharp edges. Resident #74 was originally admitted to the facility 11/24/17 and has never been discharged from the facility. The current diagnoses included; stroke, difficulty speaking, and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/22/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of 15. This indicated Resident #74's daily decision making abilities	F 677	F677 1. Resident #74 is receiving nail care per his wishes and to ensure that there are no jagged edges. 2. Residents were reviewed to ensure that nail care has been provided. 3. Charge Nurses will be educated on: " Monitoring provision of nail care " Provision of nail care as needed 4. The Unit Managers will complete a random weekly review of nail care to ensure that resident nails are not jagged and nail care has been provided. 5. Results of the review will be presented to the Quality Assurance	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 677	Continued From page 69 were severely impaired. The resident was coded in section "G" (Physical functioning) as requiring total care of one with bathing and off unit locomotion, extensive assistance of 2 people with transfers and extensive assistance of one with eating, toileting, bed mobility, on unit locomotion, dressing, and personal hygiene. Resident #74 was observed seated in the dining room awaiting the lunch meal. His fingernails were observed to be approximately 2 inches beyond the tip of the nail and most were with broken edges resulting in sharp jagged pieces of nails; capable of tearing the skin, getting caught in knit clothing, and etc. Resident #74 nodded yes, when asked if he would allow staff to cut and ensure the jagged edges were smoothed out. Resident #74's undated care plan didn't address fingernail care therefore; an interview was conducted with certified nursing assistant CNA) #1 on 5/9/19 at approximately 9:55 a.m. CNA #1 stated he was assigned to care for the resident and he was familiar with Resident #74. CNA #1 stated the resident is compliant with care therefore; that wouldn't be a reason his fingernails were long and broken. He also stated he had not focused attention on his fingernails but he would take a look at them and address identified concerns. Also on 5/9/19 at approximately 1:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated the resident preferred his fingernails longer than most residents but the broken, jagged edges were filed smoothly and the resident tolerated the fingernail care well.	F 677	Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 677	Continued From page 70	F 677		

The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Director of Nursing stated Resident 74's fingernails had been filed and the expectations for maintaining fingernail care for all residents is for the CNA to identify the need during care rounds and to cut, trim and clean the resident's fingernails as needed.

Based on observation, staff interviews and clinical record review the facility staff failed to ensure 2 of 60 residents (Resident #117 and 74) in the survey sample who were unable to carry out activities of daily living receives the necessary services to maintain fingernail care.

1. The facility staff failed to provide Resident #117 fingernail care.

2. The facility staff failed to provide fingernail care for Resident #74, prior to his fingernails becoming long and with broken sharp edges.

The findings included:

1. The facility staff failed to provide Resident #117 fingernail care.

Resident #117 was admitted to the facility on 05/15/2017. Diagnosis included but were not limited to, hemiplegia following Cerebral Infarction affecting left non-dominant side, other reduced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 677	Continued From page 71	F 677		

mobility and Peripheral Vascular Disease. Resident #117's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 04/06/2019 coded Resident #117 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #117 as requiring extensive assistance of 1 with personal hygiene, extensive assistance of 2 with bed mobility and dressing, total dependence of 2 with transfer and toilet use and total dependence of 1 with bathing.

During the tour on 05/07/2019 at 12:27 p.m., Resident #117 was observed sitting in bed and fingernails on the right hand were noted to be a brownish yellow color and approximately a half inch in length past the tip of his fingertips and curling over. Resident #117 was asked, " Do you like your fingernails to be that length?" Resident #117 stated, "No, not this long."

On 05/08/2019 at approximately 1:00 p.m., the surveyor observed Resident #117's fingernails and they remained unchanged. The surveyor asked Resident #117, "Can you show me your left hand?" Resident #117 stated, "I will try." Resident #117's left hand is very contracted, in a clinched closed position. Resident #117 was able to open his hand slightly and surveyor noted the fingernails on his left hand were a brownish yellow color, approximately a half inch in length past the tip of his finger tips and curling around his fingers.

On 05/09/2019 at 8:40 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #5 at the bedside of Resident #117. The surveyor asked LPN #5 to look at Resident #117's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 677	Continued From page 72	F 677		

fingernails on both of his hands. The LPN #5 stated, "His nails need to be clipped." Resident #117 stated, "The aide said he was going to trim my nails today." LPN #5 responded to Resident #117, "Are you going to allow him to trim your fingernails when he comes in?" Resident #117 stated, "Yes as long as he does not cut my thumb nails." Outside of Resident #117's room LPN #5 stated, "Resident #117 will say that he is going to let the staff cut his nails and then refuses. The CNA's (Certified Nursing Assistant) document when he refuses to have his fingernails trimmed." Surveyor requested copy of CNA's documentation regarding Resident #117's refusals to have his fingernails trimmed from LPN #5.

On 05/09/2019 at approximately 12:00 p.m., facility staff reported that they were unable to provide documentation that Resident #117 refused to have his fingernails trimmed.

The Administrator and Director of nursing was made aware of the findings at the pre-exit meeting on 05/09/2019 at approximately 5:45 p.m. The Director of Nursing was asked, " What are your expectations of staff concerning fingernail care?" The Director of nursing stated, "During ADL (Activities of Daily Living) rounds, I expect the CNA's to identify residents who want their nails cut and cut them accordingly as needed." The Director of nursing was asked, "How often should the residents be provided fingernail care?" The Director of nursing stated, "Staff should provide care as needed." The Director of nursing added, "Someone like Resident #117, probably need to offer nail care everyday." The Director of Nursing stated, "I cut Resident #117's fingernails today." The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 677	Continued From page 73 did not present any further information about the findings.	F 677		
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 information gleamed during a complaint investigation, resident interviews, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to provide an environment which is free from accident hazards and elopement by implementing interventions and supervision for 3 of 60 resident in the survey sample, (Resident #79, 553 and 31). 1. The facility staff failed to identify Resident #79's inability to hold her leg/foot up for prolonged periods while being propelled in a wheel chair; which resulted in an avoidable fall. 2. The facility staff failed to provide necessary supervision to Resident #553 to prevent elopement from the facility. 3. The facility staff failed to ensure Resident #31's bathroom was free from fall hazards.	F 689	F689 1. Resident #79 has had no further falls and the care plan has been revised to include appropriate interventions to prevent further falls. Resident #553 discharged on 1/9/19. Resident #31□s bathroom floor has been repaired to prevent a fall hazard. 2. Residents at risk of falls or elopement have interventions identified on their plan of care and a safe environment with adequate supervision. 3. Facility staff will be educated on: " Communication of fall hazards " Communication of unsafe behaviors Charge Nurses will be educated on: " Identification of interventions to prevent falls or elopement " Implementation of interventions to prevent falls or elopement 4. The Unit Managers will complete a random weekly review of Resident care plans to ensure that fall prevention	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 74 The findings included; 1. The facility staff failed to identify Resident #79's inability to hold her leg/foot up for prolonged periods while being propelled in a wheel chair; which resulted in an avoidable fall. Resident #79 was originally admitted to the facility 10/11/13, and was readmitted to the facility 4/22/19, after an acute care hospital stay. The current diagnoses included; stroke with left hemiparesis, and seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/23/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #79's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one with bathing, extensive assistance of one with bed mobility, transfers, dressing, personal hygiene, toileting and independent after set-up with locomotion. An interview was conducted with Resident #79 on 5/8/19 at approximately 10:43 a.m. The resident stated about a week ago she was outside with activity staff and the activity staff was propelling her in her wheel chair. The resident stated her left leg was resting on a foot rest because it is her weak leg and she was holding the right leg up by lifting it, then suddenly the right leg made contact with the pavement causing the wheel chair to come to a sudden stop and project her out of the wheel chair on to the pavement. Resident #79	F 689	interventions are identified and implemented. The Maintenance Director will complete a weekly review of Resident environment to ensure that the environment is free of hazards. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 75	F 689		

stated she sustained no injuries but it was a frightening incident.

An interview was conducted with the Activity assistant on 5/9/19 at approximately 11:00 a.m. The Activity assistant stated she was propelling Resident #79 outside, the paralyzed leg was up, the other leg was down and when they got to the slant in the sidewalk the resident's down foot hit the concrete and the resident fell from the wheel chair and rolled over on her side on the ground. The Activity assistant stated she and another staff member put the resident back in her wheelchair and took her upstairs so the nurse could assess the resident. The Activity assistant stated on the day Resident #79 fell; her supervisor educated her that if a resident doesn't have leg rest on the wheel chair the resident can't be pushed.

Review of the nurse's notes revealed a note dated 4/23/19 at 12:50, which stated fall without injury.

On 4/23/19 at 16:46, an order was obtained for an x-ray of the left lower foot and ankle related to pain post fall. The x-ray results dated 4/24/19, revealed no acute fracture or dislocation.

A facility Fall Risk Assessment was completed for Resident #79 on 4/23/19. The only risk identified were use of diuretics, anti-hypertensives, anti-seizure and antidepressant medications as well as chair bound and requires assistance with toileting.

Resident #79's care plan had an undated problem which read; the resident is at risk for falls related to deconditioning. The goals read; the resident will be free of falls through the next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 76	F 689		

review date, the resident will be free of minor injury through the review date, and the resident will not sustain serious injury through the review date. The interventions included; anticipate and meet the resident's needs. Keep the environment free of trip hazards. Be sure the resident's call light is within reach and encourage the resident to use it. Remind resident to rise slowly to prevent orthostatic hypotension. Grab bar x2, wheel chair with cushion, left foot orthotic, anti-tippers.

Resident #79's care plan did not have the intervention do not propel the resident's wheel chair without leg rest in place, prior to the 4/23/19, fall neither after the fall. The intervention was added 5/9/19.

The facility staff reviewed Resident #79's fall during the fall committee meeting on 4/26/19. The notes stated; improper use/handling of the resident in a wheel chair. The intervention was to educate the staff on not pushing the resident in the wheel chair without foot rest.

The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Director of Nursing stated Resident #79 is routinely propelled by the staff but now they understand foot rest are necessary if a staff member will be propelling the resident's wheel chair.

The facility's policy titled "Falls Management Program" dated 2/1/15 read at III. The fall management program which is to be completed by a licensed nurse as part of the admission process, Communication of fall risk and interventions to direct caregiving staff, residents,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 77 family and staff education, Fall occurrence management, Care plan development with ongoing input form the Falls Interdisciplinary Committee, Intervention implementation and evaluation of patient response and Quality Assurance review of each occurrence to include analysis of electronic Fall Tracking Date. Complaint Deficiency 2. The facility staff failed to provide necessary supervision to Resident #553 to prevent elopement from the facility. Resident #553 was admitted to the facility on 05/03/2016 and discharged to another nursing home on 01/09/2019. Diagnosis included but were not limited to, Schizoaffective Disorder, Brain Stem Stroke Disorder and Vascular Dementia with behaviors. Resident #553's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/18/2018 was coded with a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #553 as requiring supervision of 1 for locomotion on the unit and locomotion off of the unit, supervision of 1 with walking in room, limited assistance of 1 for transfer, extensive assistance of 1 with toileting, personal hygiene and total dependence on 1 with bathing. On 05/08/2019 at approximately 1:30 p.m., Resident #553's closed record was reviewed and revealed the following:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 78	F 689		

The Person Centered Plan of Care identified Resident #553 as an elopement risk/wanderer R/T (related to) impaired safety awareness, resident wanders aimlessly. Wanderguard on left ankle, initiated on 05/04/2018. The goal was that Resident #553's safety will be maintained through the review date, initiated on 08/06/2018. One of the interventions listed was: Monitor location. Notify the nurse of wandering behavior and attempted diversional interventions.

Review of the "Wandering Risk Assessment" completed on 08/03/2018 identified Resident #553 as "Known wanderer/hx (history) of wandering."

The Order Summary Report revealed an order for "Check Wander Prevention Band" every shift, ordered 08/06/2018.

On 05/09/2019 at 3:15 p.m., an interview was conducted with the Floor Technician to discuss the elopement of Resident #553. The Floor Technician stated, "(Resident name) was in the lobby ranting and raving, cursing that he wanted to go outside to smoke. I told (resident name) that I would take him outside. (Resident name) had a wanderguard on so I took him out back to smoke. After he smoked his cigarette I told him I had to go back inside and get my floor machine and I would be right back. I left (resident name) outside and I went inside. When I got back he was gone." The Floor Technician was asked, "Was a staff member outside to monitor Resident #553 when you left?" The Floor Technician stated, "No, it was not." The Floor Technician was asked, "Should Resident #553 have been left outside unsupervised?" The Floor Technician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 79	F 689		

stated, "No."

On 05/09/2019 at approximately 4:00 p.m., at pre-exit meeting the Administrator and Director of nursing was informed of the findings. An interview was conducted with The Administrator and Director of Nursing and they were asked, "What are your expectations of staff when supervising residents outside?" The Administrator stated, "Supervised smokers are only going out to smoke on Supervised Nursing Hours Only." The Director of Nursing was asked, "What are your expectations of staff when supervising residents who are wanderers?" The Director of Nursing stated, "Wanderers are supervised and not left unattended." The facility did not present any further information about the findings.

3. The facility staff failed to ensure Resident #31's bathroom was free from fall hazards.

Resident #31 was admitted to the facility on 8/5/18 with diagnoses that included but were not limited to Parkinson's disease (1), schizophrenia, and muscle weakness. Resident #31's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/22/19. Resident #31 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #31 was coded in section G (Functional Status) as being able to walk independently in his room.

On 5/9/19 at 10:00 a.m., an observation was made of Resident #31's bathroom. The vinyl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 80	F 689		

flooring was torn in several places with loose debris across the floor. The writer had loose vinyl debris stuck underneath shoes during this observation. Resident #31 could not be reached for an interview at this time.

On 5/9/19 at 10:00 a.m., Resident #31's roommate (Resident #124), saw this writer look at the bathroom and stated that he was the one who alerted maintenance about the bathroom. Resident #124 stated that he had talked to maintenance three weeks ago regarding the floor and that maintenance was in the process of getting new material. Resident #124 stated that maintenance gave him an estimated time frame of two weeks before the new flooring would come in but now that timeframe was pushed back a week. Resident #124 stated that he does not get caught up in the floor because he uses his wheelchair to propel in the bathroom and transfer when he reaches the toilet. Resident #124 stated that he could not walk. Resident #124 stated that the floor started to fall apart a year ago but that it just recently got really bad.

Review of Resident #31's clinical record revealed that he was a fall risk and has had several falls with no injury while at the facility. Resident #31's most recent falls were on 3/15/19, 2/7/19 and 12/8/18. The following was documented on the post fall assessment for all three falls: "Problems with mobility: unsteady gait/poor balance" and "history of falls."

The most recent fall dated 3/15/19 was in the resident's bathroom. The following was documented: "Resident found in his bathroom, on his knees attempting to get off floor. I asked resident, "did (sic) you fall?" resident (sic) stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 81	F 689		

"Yes I am fine." I asked resident "What were you trying to do" (sic) Resident stated I was trying to use the bathroom, (sic) resident educated. assessment (sic) completed. skin (sic) intact. Neuro checks in place. pa (physicians assistant) notified. resident (sic) is own RP (responsible party). call (sic) bell in reach. will (sic) continue to monitor." There was no evidence that Resident #31's fall was related to the flooring.

Review of Resident #31's fall risk assessment dated 3/20/19 documented the following: "Tries to stand, transfer, or walk alone independently."

Review of Resident #31's fall care plan dated 8/15/18 and revised 3/15/18 documented the following: "The resident is at risk for falls r/t (related to) limited physical mobility...The resident will be free from falls through next review date. Goals/Interventions: Anticipate and meet The resident's needs...Assistive Devices: rollator, wheelchair with cushion, neck brace, bed extender. Be sure residents call light is within reach and encourage the resident to use it. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Keep environment free of hazards."

On 5/9/19 at 12:55 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked if Resident #31 could ambulate by himself, ASM #2 stated that it was unsafe for him to ambulate on his own and that he needed supervision. ASM #2 stated that he was discouraged to walk independently. ASM#2 stated that he sometimes walks without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 82	F 689		

assistance and takes himself to the bathroom. ASM #2 stated that Resident #31 has had falls in the past and that his diagnosis of Parkinson's Disease made him unsteady on his feet and a fall risk. When asked if she had been his bathroom recently, ASM #2 stated that she had not. ASM #2 stated that she knew repairs would start soon to his bathroom. This writer asked ASM #2 to view the bathroom with this writer.

On 5/9/19 at 1:09 p.m., observation was made of Resident #31's bathroom with ASM #2. At that time Resident #31 was observed coming out of the bathroom by himself in his wheelchair. When asked ASM#2 if his bathroom was a trip hazard, ASM #2 stated, "Oh yes, it can be." When asked what could be done in the meantime while maintenance is working to get materials for the floor, ASM#2 stated that the floor could be stripped to the base floor so that there were no loose particles. ASM #2 stated that she wasn't sure how long the bathroom was in disrepair. ASM #2 stated that she hadn't seen the floor that bad until that observation with this writer. ASM #2 stated that she believed the floor was previously tile and that it was all torn up because maintenance may have removed the tile and began work. ASM #2 stated that all the bathroom floors on that hallway were tile.

On 5/9/19 at 1:11 p.m., observations were made of several bathrooms on the 300 hall. The following rooms were observed: 319, 323, 326, 321. All rooms had vinyl flooring to the bathrooms, not tile.

Review of maintenance's work orders from the past three months revealed that a work order had not been submitted for the bathroom floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 83	F 689		

On 5/9/19 at 2:22 p.m., an interview was conducted with OSM (other staff member) #2, the Director of Maintenance. When asked how he was made aware that repairs were needed in Resident's rooms and/or bathrooms, OSM #2 stated that any staff member could alert him or submit a work order. OSM #2 stated that he also does room rounding on every room at least once per week. OSM #2 stated that Resident #31's roommate had alerted him about the bathroom in early April and that the week prior (In March) he only noticed floor discoloration. OSM #2 stated that there was no work order submitted for Resident #31's bathroom, that he was only alerted by Resident #31's roommate. OSM #2 stated that since the floor has been falling apart, he has been trying to get new material to fix the floor. When asked what material the floor was made out of in Resident #31's bathroom, OSM #2 stated that it was vinyl. When asked if the material in the bathroom was a hazard for a resident who can ambulate in the bathroom, OSM #2 stated, "It could be." When asked what could be done to fix the hazard while he was waiting for the new material to come in, OSM #2 stated that he could remove any loose pieces or debris on the floor. When asked how it gets communicated to other departments including nursing, that he is waiting on material to fix the floor, OSM #2 stated that he will send emails out to every department. OSM #2 stated that it did not get communicated to nursing that he was waiting on material to fix the floor.

On 5/9/19 at 3:30 p.m., an interview was attempted with Resident #31. Resident #31 stated that he did not have time to answer questions because he was getting ready to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 84	F 689		

shower. Resident #31 stated if he had time, he would try to find this writer later.

On 5/9/19 at approximately 4 p.m., OSM #2 presented his room rounding/inspection from March 2019. There was no evidence that Resident #31's bathroom floor was in disrepair until early April 2019. The following emails were written between OSM #2 and the company used to obtain the materials:

"April 02, 2019
Goid (sic) afternoon (name of OSM #2). It was nice meeting with you yesterday. Here are the pictures (pictures of a floor) we had talked about. Let me know what you think.

April 19th, 2019 (From OSM #2)
What do you think of this type of flooring. This is being installed in other [corporate name] building.

April 19th 2019 (From company)
Looks great!

April 19th 2019 (From OSM #2)
(Name of representative at company),
Sorry for the delay, however I need you here ASAP to get those two bathrooms floor completed. Please respond ASAP.

April 19th 2019 (From company)
Yes sir. I will call you later and work out the details.

April 22, 2019 (From OSM #2)
(Name of representative at company),
I really need to get the ball rolling on the two bathrooms at my facility. I mean fast."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 85 On 5/9/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) and ASM #3, the nurse consultant were made aware of the above concerns. Facility policy titled, "Falls," documents in part, the following: "The Center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence based interventions to develop individual care strategies." No further information was presented prior to exit. (1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. Exposure to chemicals in the environment might play a role. Symptoms begin gradually, often on one side of the body. Later they affect both sides. They include Trembling of hands, arms, legs, jaw and face, Stiffness of the arms, legs and trunk, Slowness of movement, Poor balance and coordination. As symptoms get worse, people with the disease may have trouble walking, talking, or doing simple tasks. They may also have problems such as depression, sleep problems, or trouble chewing, swallowing, or speaking." This information was obtained from The National Institutes of Health. https://medlineplus.gov/parkinsonsdisease.html.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 695	Continued From page 86 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 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 interview, staff interviews, clinical record review, facility documentation review, the facility staff failed to provide 1 of 60 residents (Resident #453) in the survey sample with Respiratory care in accordance with professional standards of practice. The facility staff failed to ensure Resident #453's oxygen order contained a prescribed flow rate to be administered. The findings included: Resident #453 was admitted to the nursing facility on 05/03/19. Resident #453 diagnosis included but not limited to Pulmonary Fibrosis, hypoxia, Anxiety and Congestive Heart Failure. The resident's Minimum Data Set (MDS) assessment was not due. Resident #453's Interim care plan documented resident on oxygen therapy related to respiratory distress. The goal: Resident will have no signs of distress or poor oxygen absorption. Some of	F 695	F695 1. Resident #453 is receiving oxygen as ordered by the physician. 2. Residents receiving oxygen were reviewed to ensure that the order for oxygen included a prescribed flow rate for administration. 3. Charge Nurses will be educated on: " Obtaining order for administration of oxygen to include prescribed flow rate 4. The Unit Managers will complete a random weekly review of oxygen use to ensure that an order for administration of oxygen is present and includes a prescribed flow rate. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 695	Continued From page 87	F 695		

the intervention/approaches to manage goal included but not limited to give medications as ordered by physician and monitor for signs and symptoms of respiratory distress and report to physician as needed.

During the initial on 05/07/19 at approximately 12:07 p.m. Resident #453 was observed lying in bed with oxygen on at 2 liters minute via nasal cannula with humidification. On the same day at approximately 2:51 p.m., Resident #453 was sitting on side of the bed. The resident remains with oxygen on at 2 liters minute via nasal cannula (n/c) with humidification. The resident said she has had the oxygen on since she came.

On 05/08/19 at approximately 10:55 a.m., Resident #453 was observed sitting on the side of her bed; oxygen was on at 2 liters via n/c with humidification.

Review of Resident #453's Physician Order Sheet (POS) for May 2019 included the following order: Oxygen Therapy - Oxygen at (specify) liters per minute via nasal cannula with a start date of 05/06/19.

Review of Resident #453's medical record revealed Resident was wearing oxygen at 2 liters via nasal cannula (n/c) on the following days:
-On 05/04/19 at approximately 3:47 a.m., oxygen on at 2 liters n/c.
-On 05/06/19 at approximately 3:59 a.m., oxygen on at 2 liters via n/c.
-On 05/06/19 at approximately 3:43 p.m. (Admission Note). Uses chronic oxygen at 2 liters via n/c.
-On 05/06/19 at approximately 4:09 p.m., oxygen saturations at 98% on oxygen at 2 liters via n/c.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 695	Continued From page 88	F 695		

-On 05/07/19 at approximately 4:23 p.m., oxygen on at 2 liters via n/c.

On 05/08/19 at approximately 1:15 p.m., an interview was conducted with the facility's Nurse Consultant. The Nurse Consultant said the nurse who took report should verified all orders with the physician or Nurse Practitioner. She said there should have been a flow rate prior to administering the resident's oxygen. The surveyor review the oxygen order with the Nurse Consultant who stated she was unable to locate where the order was put in to include the flow rate of oxygen to be administered. The surveyor asked, "After you reviewed the oxygen order, how would the nurse know how much oxygen to administer" she replied, "I don't know how they would; the order does not having a flow rate."

An interview was conducted with the Director of Nursing (DON) on 05/09/19 at approximately 11:44 a.m. The surveyor asked, "Did Resident #453's oxygen order written on 05/06/19 contain the flow rate" she replied, "No, it did not." She said the nurse should have notified the physician to get clarification for the oxygen order. The DON said the oxygen order should have included the flow rate.

The facility's policy titled Respiratory/Oxygen Equipment (Revised on 08/04/15).
-Policy: Licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's order and in accordance with standards of practice.

Oxygen Therapy via Nasal Cannula, Simple Mask, and Venturi Mask may include but not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 695	Continued From page 89 limited to: -3. Set appropriate flow rate and place oxygen delivery device on the patient. Definitions: *Pulmonary fibrosis is a lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it more difficult for your lungs to work properly (http://www.mayoclinic.org). *Hypoxia - diminished availability of oxygen to the body tissues (Reference: http://medical-dictionary.thefreedictionary.com/hypoxia) *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). *Congestive Heart Failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 727	Continued From page 90 paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The facility staff failed to staff a RN for at least 8 consecutive hours a day on 10/7/17, 10/21/17 and 10/22/17. This affects all residents. The findings included: During the nursing staff review for September 1, 2017 through May 8, 2019 the facility staff was unable to verify RN presence in the facility for at least 8 consecutive hours on 10/7/17, 10/21/17 and 10/22/17, therefore; further verification was requested. On 5/9/19 at approximately 5:00 p.m., the Corporate Consultant stated they were unable to present any information verifying a RN was present in the facility for 8 consecutive hours on 10/7/17, 10/21/17 and 10/22/17.	F 727	F727 1. The facility currently ensures that a Registered Nurse works for at least 8 consecutive hours daily. 2. All residents have the potential to be affected by the deficient practice. 3. The facility staffing scheduler will be educated on: " Scheduling a Registered Nurse for 8 consecutive hours daily 4. The DON will complete a weekly review of the schedule to ensure that a Registered Nurse is scheduled and works for 8 consecutive hours daily. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 727	Continued From page 91 The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Corporate Consultant stated they didn't want to address the concern any further. The facility's policy titled "Daily Nurse Staffing Report Summary" dated 2/1/15 read; the Director of Nursing is responsible for assuring that the (name of company) Daily Nurse Staffing Report Summary is completed timely, accurately and maintained current per shift by designated nursing staff.	F 727		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 755	Continued From page 92 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to dispose of controlled medications in a secure and safe method to prevent diversion and/or accidental exposure upon inspection of 1 out of 3 medication carts. The findings include: On 5/8/19 at 11:20 a.m., during inspection of a medication cart, the narcotic count for *oxycodone 5 milligrams (mg) was short 1 tablet. Upon inspection with the Licensed Practical Nurse (LPN) #7 the count was 9 tablets of oxycodone, but the narcotic sign out sheet recorded 10 on 5/8/19 at 9:00 a.m. LPN #7 stated she dropped the tablet and was going to have (name of Assistant Director of Nursing) waste the tablet with her. She did not respond when asked what she did with the oxycodone tablet. *Oxycodone, a class II narcotic, is a semisynthetic derivative of codeine that acts as a narcotic analgesic more potent and addicting than codeine. (https://www.drugbank.ca/drugs/DB00497)	F 755	F755 1. LPN #7 was educated on disposal of controlled medications in a secure and safe method to prevent diversion and/or accidental exposure. 2. All residents have the potential to be affected by the deficient practice. 3. Charge Nurses will be educated on: " Disposal of controlled medications " Documentation of disposal of controlled medications 4. The DON will complete a random weekly review of controlled medication narcotic count sheets to ensure that disposal of the narcotic was witnessed. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 755	Continued From page 93 On 5/8/19 at 11:30 a.m., the ADON stated she did not know about LPN #7 dropping the narcotic, but she could have asked any licensed nurse to waste the tablet and expected that she would have done so. The ADON stated she was training a new Unit Manager and had been on the unit all morning and was not sure why she did not ask her to witness the waste the oxycodone tablet. She stated that retraining would take place with the LPN. On 5/8/19 at 1:00 p.m., the nurse consultant stated LPN #7 stated she threw the oxycodone tablet in the sharps container and presented a picture of tablet that had been retrieved from the sharps container. She stated LPN #7 did not follow the facility's policy and procedure (dated 3/28/19) on the disposal/waste of controlled medications by two licensed nurses with the disposal documented on the accountability record on the line representing the dose.	F 755		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews the facility staff failed to ensure food was served at a palatable and appetizing	F 804	F804 1. Resident #17 is receiving food at a palatable and appetizing temperature.	6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 804	Continued From page 94 temperature for 1 resident (Resident #17) out of 60 residents in the survey sample. The facility staff failed to ensure Resident #17's food was served at a palatable and appetizing temperature. The findings included: Resident #17 was admitted to the facility on 09/02/2014. Diagnosis for Resident #17 included but are not limited to Heart Failure and Unspecified Dementia. Resident #17's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 02/07/2019 coded Resident #17 with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the MDS coded Resident #17 as requiring no assistance with eating - setup help only, extensive assistance of 1 with bed mobility, transfer, dressing, and personal hygiene, and total dependence of 1 for toilet use and bathing. On 05/08/2019 at 1:38 p.m., during the resident council meeting at least 5 residents agreed that the food was cold. Six months of resident council meeting notes were reviewed and showed: 11/13/2018 residents complained of cold foods 01/08/2019 cold foods 02/12/2019 cold foods 04/09/2019 ongoing issues, cold foods. An interview was conducted with Resident #17 on 05/08/2019 at 1:47 p.m. Resident #17 was asked, "How do you like your food?" Resident #17 stated, "Sometimes my food comes cold. My sausage will be cold. I don't like it cold."	F 804	2. All residents were potentially affected by the deficient practice. 3. Dietary staff will be educated on: " Tray Service Evaluation " Communication that carts have arrived to the unit Nursing staff will be educated on: " Timely delivery of meal trays " Communication of Resident complaint of lukewarm food " Proper re-heating of food using microwave 4. The Dietary Manager/Diet Tech will complete a random weekly review of food temperatures to ensure that foods are served at a palatable and appetizing temperature. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 804	Continued From page 95	F 804		

On 05/09/2019 at 11:50 a.m., the surveyor observed the meal carts that arrived to the 3rd floor and were placeded in front of the nurse's station. At 12:06 p.m., surveyor observed staff push the meal carts to East Wing on 3rd floor. At 12:35 p.m., surveyor observed staff serve Resident #17 her meal tray.

On 05/09/2019 at 12:37 p.m., an interview was conducted with Resident #17 and she was asked, "How does your food look?" Resident #17 stated, "It does not look appetizing. The potatoes feel cold." Resident #17 stated, "I'm not going to eat the potatoes. I will eat my sandwich." The surveyor asked Resident #17 to place a piece of potato in the surveyor's hand since she wasn't going to eat them. The potato was noted to be luke warm to the touch.

On 05/09/2019 at approximately 12:40 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. The surveyor made LPN #5 aware of the observations concerning the amount of time it took to deliver the meal tray to Resident #17's room. The surveyor handed LPN #5 the piece of potato from Resident #17's meal tray in a napkin and made her aware that the potato was luke warm when touched by the surveyor. The Unit Manager stated, "I was in a resident's room and I didn't see when the carts arrived." The Unit Manager also stated, "If the housekeeping carts are on the units nursing has to wait for housekeeping to remove the carts from the unit before they can serve the meal trays. Housekeeping staff usually takes their carts off of the unit as soon as they see the meal carts come up."

The Unit Manager was asked, "What are your

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 804	Continued From page 96 expectations of staff when delivering meal trays?" The Unit Manager stated, "I expect the nursing staff to start delivering trays as soon as the housekeepers remove their carts." The Unit Manager stated, "I will order another tray for Resident #17." The Administrator and Director of Nursing was made aware of the findings at the pre-exit meeting on 05/09/2019 at approximately 5:45 p.m. The Director of Nursing and Administrator was asked, "What are your expectations of staff when delivering meal trays? The Administrator stated, "I expect the residents to receive their trays, food be palatable and trays be delivered timely." This is a Complaint Deficiency.	F 804		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following	F 849		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 849	Continued From page 97	F 849		

requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 849	Continued From page 98	F 849		

care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 849	Continued From page 99	F 849		

agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 849	Continued From page 100 (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of the Hospice policy; the facility staff failed to integrate the Hospice Agency's written agreement describing the responsibilities between the hospice agency and the nursing home for 1 of 60 residents (Resident #92), in the survey sample. The facility staff failed to ensure the Hospice Agency's coordinated plan of care for Resident #92, to identify which services the Hospice Agency would provide, when the services would be provided, the communication process, and when or why the nursing facility staff should notify the Hospice Agency was integrated with the facility's care plan.	F 849	F849 1. Resident #92□s plan of care was revised to incorporate Hospice services. 2. Residents receiving Hospice services were reviewed to ensure that the plan of care integrates the services provided by Hospice. 3. Nursing staff will be educated on: " Integration of the Hospices services provided in the facility plan of care 4. The Unit Managers will complete a weekly review of Residents receiving Hospice services to ensure that the services are incorporated in the facility plan of care. 5. Results of the review will be presented to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 849	Continued From page 101 The findings included: Resident #92 was admitted to the facility 12/1/15 and was discharged from the facility to a local acute care hospital 6/22/18 and returned 6/25/18. The current diagnoses include; legal blindness, bilateral hearing loss and dementia. The quarterly MDS assessment with an assessment reference date (ARD) of 4/1/19 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 total care with bathing, personal hygiene, and toilet use, extensive assistance with eating, dressing and bed mobility. Review of the May 2019 physician's order summary revealed an order dated 6/27/19, which read; admit to (name of the hospice agency) for a diagnosis of dementia. Continue current medications in the facility and start comfort medications. Another physician's order dated 6/29/18 read; other treatment restrictions; do not resuscitate (DNR), no weights, and hospice care. Review of the undated person-centered plan of care revealed a problem which read; the resident has a terminal prognosis, do not resuscitate, no hospitalizations and no weights. The goal read; the resident's comfort will be maintained through the review date. The interventions included; assist resident with coping strategies and respect resident wishes, observe resident closely for signs of pain, administer pain medications as ordered and notify the physician immediately if	F 849	Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 849	Continued From page 102	F 849		

there is breakthrough pain.

The undated person-centered plan of care didn't include any information about the election of hospice services on 6/27/18, the name of the hospice agency, contact information for the hospice agency, the coordinated plan of care; which includes services the hospice agency would provide, when the services would be provided, the communication process, and when or why the nursing facility staff should notify the hospice agency.

An interview was conducted with certified nursing assistant CNA) #1 on 5/9/19 at approximately 9:55 a.m. CNA #1 stated he was assigned to care for the resident and he was very familiar with Resident #92. CNA #1 stated he was aware the resident received hospice services because he often sees the hospice nurse in her room and this day the hospice nurse fed the resident her breakfast, but CNA #1 was unaware of days or times the hospice staff visits Resident #92.

An interview was conducted with the MDS Coordinator 5/9/19 at approximately 10:10 a.m. The MDS Coordinator stated he didn't realize the facility's care plan did not include hospice services and the hospice agency's plan of care wasn't included with the facility's care plan. The MDS Coordinator further stated her would obtain a copy of the hospice agency plan of care and ensure they were integrated. At approximately 4:00 p.m., the MDS Coordinator stated Resident #92's person-centered plan of care had been revised to include hospice services and the hospice agency's plan of care.

The above findings were shared with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 849	Continued From page 103 Administrator, Director of Nursing and the Corporate Consultant on 5/9/19 at approximately 5:10 p.m., the Director of Nursing stated Resident #92's care plan included terminal illness. The facility's policy title "Terminal Illness/Death or Dying" dated 4/25/18 read; under procedure 1. Review resident's medical record for advanced directive. Procedure 2. If an advanced directive is located, ensure the Center and physician are aware of the resident's decision regarding advanced directives and decisions regarding care and services.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 104 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 880	Continued From page 105 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, facility documentation review, and staff interview the facility staff failed to ensure infection control measures were provided during wound care and the facility staff failed to conduct a risk assessment to reduce the risk of Legionella on 1 residents. (Resident #55) of 60 residents in the survey sample. For Resident #55, the facility staff failed to place a barrier under the Resident's Right Lower Extremity (right heel) while providing wound care and to sanitize equipment used in wound care (scissors and bedside table). The findings included: Resident #55 was admitted to the facility on 12/12/18 and readmitted to the facility on 02/28/19. Diagnosis for Resident #55 included but not limited to Pressure Ulcer of Unspecified, Pressure Ulcer of Right Hip, and Major Depressive Disorder. The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 02/19/19. Staff assessment of mental status coded the resident as having short term memory problems. In section "G" (Physical functioning) the MDS scored Resident #55 as requiring total dependence with 2 staff persons for Transfers. Resident #55 was coded as requiring total	F 880	F880 1. Resident #55 is receiving wound care using appropriate infection control measures and a risk assessment was completed to reduce the risk of Legionella. 2. Residents with wounds were reviewed to ensure staff are using appropriate infection control measures. The facility has included a risk assessment to reduce the risk of Legionella in the facility infection control program. 3. Charge Nurses will be educated on: " Infection control measures for wound care The Infection Control Preventionist and Maintenance Director will be educated on: " Risk assessment to reduce the risk of Legionella 4. The Unit Managers and Staff Educator will complete random weekly treatment observations to ensure that wound care is provided using appropriate infection control measures. The DON will complete a weekly review of documentation of risk assessment of Legionella. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 880	Continued From page 106	F 880		

dependence with one staff person assistance for Dressing, Hygiene, and Bathing. In section "N" (Skin Conditions) resident was coded as having two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.

Resident #55's Revised Care Plan on 03/18/19 documented a focus area of:
Potential for skin impairment/pressure ulcer development.
Actual Impairment: Right Heel.
Goal: Resident will have no evidence of skin impairment through the next review. Revised on 3/18/19.
Interventions: Air loss Mattress, Prevalon Boots. Keep Skin Clean and dry. Weekly Skin Assessment. Wound Care as ordered.

Resident #55 physician orders documented the following:
MD order dated 03/29/19: Cleanse Right heel wound with normal saline. Apply santyl ointment to right heel topically every day shift for wound healing. Cover with dry gauze and kerlix daily and as needed.

Licensed Practical Nurse (LPN) #3 was observed performing wound care on 05/07/19 at approximately 4:10 PM. LPN #3 did not utilize infection control measures during wound care because no barrier was placed under Resident's Right heel. Instead of using a barrier Resident's right heel was placed on the bed and also placed resident's right heel on top of his left foot thereby increasing his chances of cross contamination. When wound care was completed LPN #3 did not sanitize the bed side table nor did she sanitize her scissors after completing wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 880	Continued From page 107 The following steps were observed during wound care: Performed hand hygiene. Donned gloves. Retrieved bedside table and disinfected table with a sani cloth. Allowed table to dry. Removed gloves. Performed hand hygiene. Donned gloves. Applied sterile drape to bed side table. Assembled supplies on drape. (gauze, normal saline, santyl, kerlix, hypaflix) forgot scissors-going to find them.. got scissors premedicated resident for pain. received permission from resident. nodded head yes. removed kerlix placed heel on bed added normal saline soak gauze to heel placed heel on resident's sock. Performed hand hygiene. Donned gloves. Applied nickel thick amount of santyl on gauze. Raise Resident's right heel Applied gauze, kerlix Resident was asked if he was okay by LPN #3. He shook his head yes. Dressing dated initial, time placed. (Did not change gloves) Gloves changed, placed cover on resident. Placed call bell in reach. Bed in lowest position. Removed gloves. Placed soiled items in trash bag. Unclean scissors placed on Resident's table. Bed side table not sanitized.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 108	F 880		

Performed hand hygiene.
In opened supplies placed in cart.
scissors remain on cart
cart pushed in clean linen.
scissors removed.
Wound care completed at 4:28 PM.
No barrier was placed under residents lower extremity while wound care was being provided.

On 05/09/19 at approximately 4:24 PM, a wound care policy was received from the Nurse Consultant. A review of the facility policy titled, "General Wound Care/Dressing Changes" with an effective date of 02/01/15.
The Policy states: A licensed nurse will provide wound care/dressing changes as ordered by the physician.
The Procedure states: #3 Provide Treatments as ordered. #4 Remove and reapply dressings as ordered and /or indicated.

On 05/09/19 at approximately 10:42 AM an interview was conducted with the Director of Nursing (DON) and Registered Nurse #2,(Infection Control Nurse). Concerning wound care observations on Resident #55. The above findings were discussed. Registered Nurse #2 stated that "We provide barriers, it goes under your patient to keep infection control." "All equipment should be cleaned with disinfectant when done."

On 5/09/19 at approximately 10:52 AM a phone call to Licensed Practical Nurse #3, was made by the DON concerning wound care observations. The DON was not able to leave a message.

On 05/09/19 at approximately 5:30 PM a Pre-exit interview was conducted. The Administrator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 109 Director of Nursing and Nurse Consultant were present. The above findings were discussed concerning the wound care observations. The DON stated that "A barrier should have been placed under the resident's extremity and the bedside table should have been disinfected."	F 880		