State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0124	A. BUILDING: _____ B. WING _____	C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/22/19 through 10/24/19. Nine complaints were investigated during the survey. The facility was not in compliance with the following Regulations for the Licensure of Nursing Facilities. The census in this 169 certified bed facility was 156 at the time of the survey. The survey sample consisted of 63 resident reviews: 56 current residents and 7 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff failed to be in compliance with the following Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-150 (B.1) (C). Resident Rights. Cross Reference to F600, F622, F623 and F625. 12 VAC 5-371-160 (B.1). Financial controls and resident funds. Cross Reference to F567. 12 VAC 5-371-170 (B.1 &2). Quality Assessment and assurance. Cross Reference to F867 and F868. 12 VAC 5-371-180 (A). Infection Control. Cross Reference to F880 and F925. 12 VAC 5-371-220 (A, B, D & H). Nursing Services. Cross Reference to F658, F692, F695 and F760.	F 001	12 VAC 5-371-150 (B.1) (C). Resident Rights. Cross Reference to F600, F622, F623 and F625. 12 VAC 5-371-160 (B.1). Financial controls and resident funds. Cross Reference to F567. 12 VAC 5-371-170 (B.1 &2). Quality Assessment and assurance. Cross Reference to F867 and F868. 12 VAC 5-371-180 (A). Infection Control. Cross Reference to F880 and F925. 12 VAC 5-371-220 (A, B, D & H). Nursing Services. Cross Reference to F658, F692, F695 and F760. 12 VAC 5-371-220 (A, B & C)(1). Nursing Services. Cross Reference to F686, F698,	12/8/19

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

Electronically Signed | 11/21/19

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F 001	Continued From page 1 12 VAC 5-371-220 (A, B & C)(1). Nursing Services. Cross Reference to F686, F698, and F760. 12 VAC 30-20-240 (C) (10). Physician Services. Cross Reference to F578. 12 VAC 5-371-250 (A, D, E, C & F). Resident Assessment & Care Planning. Cross Reference to F641, F656 and F657. 12 VAC 5-371-300 A, J1. Pharmaceutical Services. Cross Reference to F755. 12 VAC 5-371-310 (B). Diagnostic Services. Cross Reference to F773 12- VAC-5-371-340 (B). Dietary Services. Cross Reference F812 12 VAC 5-371-360 (A). Clinical Records. Cross Reference to F661 and F842 12- VAC-5-371-370 (F). Maintenance and Housekeeping. Cross Reference to F584 and F921. 12 VAC 5-371-150 (H). Resident Rights. Based on staff interview, and facility documentation review, the facility staff failed to ensure compliance with state licensure requirements for 1 (Resident #138) of 63 residents in the survey sample. The facility staff failed to ensure Resident #138 or resident representative was provided with information on how to and obtain signed acknowledgement, for accessing the Sex Offender Registry. The findings included:	F 001	and F760. 12 VAC 30-20-240 (C) (10). Physician Services. Cross Reference to F578. 12 VAC 5-371-250 (A, D, E, C & F). Resident Assessment & Care Planning. Cross Reference to F641, F656 and F657. 12 VAC 5-371-300 A, J1. Pharmaceutical Services. Cross Reference to F755. 12 VAC 5-371-310 (B). Diagnostic Services. Cross Reference to F773 12- VAC-5-371-340 (B). Dietary Services. Cross Reference F812 12 VAC 5-371-360 (A). Clinical Records. Cross Reference to F661 and F842 12- VAC-5-371-370 (F). Maintenance and Housekeeping. Cross Reference to F584 and F921. 12 VAC 5-371-150 (H) Resident Rights: 1. Resident or resident representative #138 has signed the acknowledgement for accessing the Sex Offender Registry. 2. All residents have the potential to be affected. Review of residents admitted October 2019 was conducted and identified residents without the signed acknowledgement have been signed. This will be completed by 11/30/19. All newly admitted residents will have a signed acknowledgement for accessing	

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F 001	Continued From page 2 Resident #138 was admitted to the facility on 11/01/18. She has never been discharged. Diagnosis for Resident #138 included but are not limited to Anxiety disorder. Resident #138's Minimum Data Set (MDS-an assessment protocol) a quarterly with an Assessment Reference Date of 10/07/19, scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. An interview was conducted with the Administrator on 10/24/19 at approximately 1:13 p.m. He was asked to provide evidence that the facility provided Resident #138 with information on how to assess the Sex Offender Registry and evidence that the facility obtained signed acknowledgement from Resident #138. On the same day at approximately 3:20 p.m., the Administrator stated, "I am unable to locate evidence in the resident's medical record of the information request." The Administrator, Director of Nursing and Nurse Consultant Corporate was informed of the finding during a briefing on 10/24/19 at approximately 4:08 p.m. The facility did not present any further information about the findings. The facility's policy titled sex Offender Registry Review on Admission (Last Revision 11/07/18). -Guidelines include but not limited to: 3. If a resident is admitted staff will print registry information and maintain privacy and confidentiality by placing the registry information in a separate file maintained by social services. 12VAC5-371-220 (F).Nursing Services.	F 001	the Sex Offender Registry. 3. Education on providing information to the resident or resident representative and signing the acknowledgement for accessing the Sex Offender Registry was completed with the Admissions Coordinator by 11/30/19. This training will also be provided to all admissions coordinators upon hire during orientation. 4. Ongoing audits by the Admissions Coordinator will be conducted for observation and review to ensure the resident or resident representative was provided with information on how to obtain signed acknowledgement for accessing the Sex Offender Registry. These audits will be conducted weekly x 4 weeks and monthly x 3. These audits will also include no less than 10% of the admissions to the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Admissions Coordinator is responsible for	

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F 001	Continued From page 3 Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for one resident in the survey sample (Resident #131) who was unable to independently carry out activities of daily living (ADL's). The facility staff failed to ensure Resident #131 was offered and received scheduled twice-weekly showers to maintain good personal hygiene. The findings included: Resident #131 was originally admitted to the facility on 12/02/16 and returned on 09/21/19. Diagnoses for Resident #131 included but not limited to, Difficulty waking and Muscle weakness. Resident #131's Minimum Data Set (an assessment) with an Assessment Reference Date (ARD) of 09/27/19 coded the resident's Brief Interview for Mental Status (BIMS) score 9 of a possible 15 which shows moderate cognitive impairment. In addition, the MDS coded Resident #131 as being totally dependent with toilet use, bed mobility, transfers, dressing, bathing and personal hygiene. The comprehensive care plan with a revision date of 10/09/19 documented Resident #131 as being limited in ability to maintain grooming/personal hygiene relating to history of CVA(Cerebral Vascular Accident) and bilateral AKA (Above Knee Amputation). The goal: Resident will be well groomed by staff daily. Approach: Provide assistance/full staff performance for washing/drying face, hands and perineum. During the initial tour on 10/22/19 at	F 001	implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019. 12VAC5-371-220 (F) Nursing Services 1. Resident #131 has been offered and provided showers as per the twice weekly schedule. 2. All residents have the potential to be affected. Review of shower schedule and validation completed to ensure residents desiring a shower receive it as per the twice weekly shower schedule.. This will be completed by 11/30/19. All newly admitted residents will have showers scheduled and provided twice weekly. 3. Education on offering and providing showers was completed with the Certified Nursing Assistants and the Licensed Nurses by 11/30/19. This training will also be provided to all CNAs and Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure residents are offered and receive showers as scheduled twice weekly to maintain good personal hygiene. These audits will include 5 residents per unit daily x 4 weeks, 2 residents per unit weekly x 2 weeks, and 2 residents per unit monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting	

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F 001	Continued From page 4 approximately, 11:28 AM the resident stated, when he asked the CNA's (Certified Nursing Assistants) about getting a shower they would say "I'll be back." "No shower or anything." "I'm suppose to get a shower every Monday and Thursday." "The aides hide their badges so that I won't report them to the DON (Director of Nursing)." On 10/23/19 at approximately,10:03 AM a review of the shower book was conducted. No showers were found in shower book for Mondays. An interview was conducted with the Unit Manager, Licensed Practical Nurse (LPN #1) She was asked if Resident's showers couldn't be located in the shower book where could information be found? She stated, "In the ADL section in the computer." The review of Unit 2's shower schedule indicated that Resident #131 was scheduled to receive his shower twice a week on Mondays and Thursdays. A review of Resident 131's ADL Verification Worksheet revealed that showers were not given on the following shower days: August 2019: 8/1, 8/5 ,8/8, 8/15, 8/22, 8/26, & 8/29. September 2019: Resident was hospitalized from 09/03-09/21. No other records were found. October 2019: 10/03, 10/14, & 10/21. On 10/24/19 at approximately, 2:47 PM Interview was conducted with LPN #6 concerning Resident #131 not receiving scheduled showers. She stated that Resident #131 was admitted to the hospital from 9/03/19- 9/21/19. She also stated that Resident #131 was refusing to get up. She was asked to provide documentation to provide	F 001	monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 001	Continued From page 5 shower refusals. No documentation was received.	F 001		