State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.		С		
		VA0124	B. WING		10/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
SIGNATUI	RE HEALTHCARE OF NO	REOLK 1005 HAN	IPTON BLVD			
OIOIVATOI	CE HEAETHOAKE OF NO	NORFOL	K, VA 23507			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D BE COMPLETE	
F 000	Initial Comments		F 000			
	10/24/19. Nine compl during the survey. Th compliance with the for Licensure of Nursing The census in this 16 156 at the time of the	acted 10/22/19 through aints were investigated e facility was not in collowing Regulations for the Facilities. 9 certified bed facility was survey. The survey sample ent reviews: 56 current				
F 001	Non Compliance		F 001		12/8/19	
	The facility was out of following state licensu					
	-	et as evidenced by: I to be in compliance with ons for the Licensure of		12 VAC 5-371-150 (B.1) (C). Resident Rights. Cross Reference to F600, F62 F623 and F625.		
		.1) (C). Resident Rights. 600, F622, F623 and F625.		12 VAC 5-371-160 (B.1). Financial controls and resident funds. Cross Reference to F567.		
	12 VAC 5-371-160 (B resident funds. Cross	.1). Financial controls and s Reference to F567.		12 VAC 5-371-170 (B.1 &2). Quality Assessment and assurance. Cross		
	and assurance. Cross	.1 &2). Quality Assessment s Reference to F867 and		Reference to F867 and F868.		
	F868.) Infaction Control Cooper		12 VAC 5-371-180 (A). Infection Cont Cross Reference to F880 and F925.	rol.	
	Reference to F880 ar). Infection Control. Cross nd F925.		12 VAC 5-371-220 (A, B, D & H). Nurs Services. Cross Reference to F658, F	_	
	12 VAC 5-371-220 (A Services. Cross Refe	, B, D & H). Nursing erence to F658, F692, F695		F695 and F760.		
	and F760.			12 VAC 5-371-220 (A, B & C)(1). Nurs Services. Cross Reference to F686, F		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 11/21/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
		VA0124	B. WING		C 10/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
SIGNATUI	RE HEALTHCARE OF NO	ORFOLK	PTON BLVD		
			K, VA 23507		
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F 001	Continued From page	e 1	F 001		
F 001	12 VAC 5-371-220 (A Services. Cross Refe F760. 12 VAC 30-20-240 (C Cross Reference to F 12 VAC 5-371-250 (A Assessment & Care I to F641, F656 and F6 12 VAC 5-371-300 A Services. Cross Reference to F 12 VAC 5-371-310 (E Cross Reference to F 12- VAC-5-371-340 (Reference F812) 12 VAC 5-371-360 (A Reference to F661 and 12- VAC-5-371-370 (Housekeeping. Cross F921. 12 VAC 5-371-150 (F Based on staff intervited ocumentation reviewensure compliance we requirements for 1 (R	A, B & C)(1). Nursing erence to F686, F698, and C) (10). Physician Services. 578. A, D, E, C & F). Resident Planning. Cross Reference 657. J1. Pharmaceutical rence to F755. A). Diagnostic Services. C773 B). Dietary Services. Cross A). Clinical Records. Cross and F842 F). Maintenance and a Reference to F584 and A). Resident Rights. ew, and facility staff failed to ith state licensure esident #138) of 63	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 Plannin Cross Reference to F641, F656 and F12 VAC 5-371-300 A, J1. Pharmaceut 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 Reference F812. 12 VAC 5-371-360 (A). Clinical Record Cross Reference to F661 and F842. 12- VAC-5-371-370 (F). Maintenance Housekeeping. Cross Reference to F661 and F921. 12 VAC 5-371-150 (H) Resident Right In Resident or resident representat #138 has signed the acknowledgement accessing the Sex Offender Registry.	g. 7657. rical ces. ds. rand rand rand rand rand rand rand rand
	failed to ensure Residue representative was p	rovided with information on ned acknowledgement, for fender Registry.		2. All residents have the potential to 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. A newly admitted residents will have a signed acknowledgement for accessing	d NII

State of V	/iigiiiia						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		URVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					_	_	
			B WING				
		VA0124	B. WING		10/2	4/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE ZIP CODE			
TO WILL OF T	NOVIBER OR COLL FEEL			(12, 211 00b2			
SIGNATUI	RE HEALTHCARE OF N	ORFOLK	IPTON BLVD				
		NORFOLI	K, VA 23507				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE	
				BEHOLENOTY			
F 001	Continued From pag	e 2	F 001				
		admitted to the facility on		the Sex Offender Registry.			
	11/01/18. She has n	ever been discharged.					
	Diagnosis for Reside	ent #138 included but are not		3. Education on providing information	on to		
	limited to Anxiety dis-	order.		the resident or resident representative	-		
	•			signing the acknowledgement for	•		
	Resident #138's Mini	imum Data Set (MDS-an		accessing the Sex Offender Registry	was		
	assessment protocol	•		completed with the Admissions			
		nce Date of 10/07/19, scored		Coordinator by 11/30/19. This training	lliw r		
		and long term memory		also be provided to all admissions	, ····		
		evere cognitive impairment -		coordinators upon hire during orientat	ion		
	never/rarely made de	- · · · · · · · · · · · · · · · · · · ·		assistant apon mo daming one mattern.			
	Hever/rarely made de	ecisions.		4 Ongoing guidite by the Admission	•		
	A i t	- du ata du vitta tla a		4. Ongoing audits by the Admission	5		
	An interview was cor			Coordinator will be conducted for			
		24/19 at approximately 1:13		observation and review to ensure the			
		to provide evidence that the		resident or resident representative wa			
		ident #138 with information		provided with information on how to o			
		e Sex Offender Registry and		signed acknowledgement for accessir	-		
	evidence that the fac			the Sex Offender Registry. These au			
	_	om Resident #138. On the		will be conducted weekly x 4 weeks a			
	same day at approxi	mately 3:20 p.m., the		monthly x 3. These audits will also inc	lude		
	Administrator stated,	"I am unable to locate		no less than 10% of the admissions to			
	evidence in the resid	ent's medical record of the		center. All data will be summarized a	nd		
	information request."	•		presented to the facility Quality Assura	ance		
				and Performance Improvement meeting	ng		
	The Administrator, D	irector of Nursing and Nurse		monthly by the Administrator. Any issu	-		
	Consultant Corporate	e was informed of the finding		or trends identified will be addressed			
		10/24/19 at approximately		the QAPI committee as they arise and	,		
		y did not present any further		plan will be revised to ensure continue			
	information about the			compliance. The QAPI committee cor			
	miorination about the	s initianings.		of the Administrator, DON, Staff	0.00		
	The facility's policy ti	tled sex Offender Registry		Development Coordinator, MDS			
		n (Last Revision 11/07/18).		coordinator, Admission Coordinator,			
	LICENCE ON AUTHOSIO	11 (Last Nevision 11/01/10).		Rehabilitation Manager, Medical Direct	etor		
	-Guidelines include b	out not limited to:		Director of Social Services, and	λΟΙ,		
				•	ore		
		mitted staff will print registry		Environmental Services. Other memb	CI S		
	information and mair			may be assigned as the need should			
		cing the registry information		arise.			
	ın a separate file mai	intained by social services.					
				5. The Administrator and Admission	s		
	12VAC5-371-220 (F)	.Nursing Services.		Coordinator is responsible for			

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		VA0124	B. WING		C 10/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
SIGNATUI	RE HEALTHCARE OF NO	ORFOLK	PTON BLVD , VA 23507		
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F 001	Continued From page	e 3	F 001		
	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			implementing and maintaining the acceptable plan of correction. Correct action to be completed by December 8 2019.	3,
	failed to ensure Residueceived	dent #131 was offered and		12VAC5-371-220 (F) Nursing Services	5
	scheduled twice-weel good personal hygien	kly showers to maintain ne.		1. Resident #131 has been offered provided showers as per the twice we schedule.	
	The findings included	:		All residents have the potential to	he
	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			affected. Review of shower schedule a validation completed to ensure resider desiring a shower receive it as per the twice weekly shower schedule. This be completed by 11/30/19. All newly admitted residents will have showers scheduled and provided twice weekly. 3. Education on offering and providing affects of the potential to affect the potential the potential to affect the potential the potential the potential to affect the potential the	and nts will
	possible 15 which she impairment. In addition #131 as being totally	Status (BIMS) score 9 of a bws moderate cognitive on, the MDS coded Resident dependent with toilet use, s, dressing, bathing and		showers was completed with the Certi Nursing Assistants and the Licensed Nurses by 11/30/19. This training will be provided to all CNAs and Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of	also
	of 10/09/19 documen limited in ability to ma hygiene relating to his Vascular Accident) ar	erformance for hands and perineum.		4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review ensure residents are offered and rece showers as scheduled twice weekly to maintain good personal hygiene. The audits will include 5 residents per unit x 4 weeks, 2 residents per unit weekly weeks, and 2 residents per unit month 3. All data will be summarized and presented to the facility Quality Assura and Performance Improvement meeting	to ive ese daily x 2 ance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE ZID CODE	10/24/2019	
NAME OF FROVIDER OR SUFFLIER		MPTON BLVD	ATE, ZIF CODE		
SIGNATURE HEALTHCARE OF NO	RFOLK	.K, VA 23507			
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
F 001 Continued From page	9 4	F 001			
approximately, 11:28 when he asked the C Assistants) about get say "I'll be back." "No suppose to get a shor Thursday." "The aide won't report them to t Nursing)." On 10/23/19 at appro of the shower book w were found in shower interview was conduct Licensed Practical Nu asked if Resident's sh the shower book whe found? She stated, " computer." The review of Unit 2's that Resident #131 w shower twice a week A review of Resident Worksheet revealed t on the following show August 2019: 8/1, 8/5 8/29. September 2019: Res 09/03-09/21. No othe October 2019: 10/03, On 10/24/19 at appro was conducted with L #131 not receiving so stated that Resident # hospital from 9/03/19	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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, &		monthly by the Administrator. Any or trends identified will be address the QAPI committee as they arise plan will be revised to ensure concompliance. The QAPI committee of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinat Rehabilitation Manager, Medical Director of Social Services, and Environmental Services. Other may be assigned as the need shourise. 5. The Administrator and Direct Nursing is responsible for implemental maintaining the acceptable procrection. Corrective action to be completed by December 8, 2019.	sed by e and the tinued e consists for, Director, embers ould or of eenting lan of	

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NORFOLK (A) ID PREPIX I (EACH DEFICIENCY MUST BE PRECEDED BY TRULL TAG TAG FOUL Continued From page 5 shower refusals. No documentation was received.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1005 HAMPTON BLVD NORFOLK, VA 23507 (X4) ID PREFIX TAG F 001 Continued From page 5 STREET ADDRESS, CITY, STATE, ZIP CODE 1005 HAMPTON BLVD NORFOLK, VA 23507 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE DATE F 001 F 001 Continued From page 5 F 001			VA0124	B. WING		1			
SIGNATURE HEALTHCARE OF NORFOLK NORFOLK, VA 23507		NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
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