STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 8/09/22 through 8/11/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/09/22 through 8/11/22. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care requirement(s) and corrections are required. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 33 certified bed facility was 26 at the time of the survey. The survey sample consisted of 17 current Resident reviews and 5 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility	F 607	1. Reference checks and sworn	9/16/22

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

Electronically Signed | 09/02/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 607	Continued From page 1 documentation review, the facility staff failed to implement their abuse policy regarding the screening of employees for 9 employees no reference checks were obtained and for 3 employees no sworn disclosure statements were obtained in a sample of 19 employee records reviewed. The findings included: On 8/11/22, a review of 19 employee files was conducted and revealed the following: 1. The facility staff failed to obtain employee References for nine employees. The employee record review revealed that 9 current employees did not have reference checks. Employee #1 hired on 10/11/21, employee #2 hired on 9/15/21, employee #3 hired on 12/08/21, employee #4 hired on 1/27/22, employee #5 hired on 2/28/22, employee #15 hired 4/20/22, employee #16 hired on 1/15/21, employee #17 hired on 4/18/22 and employee #18 hired on 8/01/21. 2. The facility staff failed to obtain Sworn Disclosure Statements for three employees: Employee #1 was hired on 10/11/21, employee #2 was hired on 9/15/21 and employee #3 was hired on 1/28/21. On 8/11/22 at approximately 4:50 PM., the above findings were shared with the Administrator. The administrator said that they were not able to locate the documents. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. Review of the facility's policy entitled, "Preventing	F 607	statements have been completed for those staff records identified as deficient. 2. All current employee files will be audited to ensure compliance with the facility policy for screening of new employees. 3. Personnel responsible for new hire paperwork completion was in-serviced on the policy and required documents for screening new employees. 4. The Human Resources manager/ designee will conduct audits on all new employee files for a period of six weeks to ensure compliance. Audit results and any trends will be reported to the Quality Assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 607	Continued From page 2 Resident Abuse", Reads: "It is the policy of Harbor's Edge to provide care in a manner that is professional, compassionate, and respectful of residents' rights. Abuse, neglect, mistreatment, and misappropriation of resident funds will not be tolerated. Harbor's Edge implements a program of screening, prevention, and facility response that minimizes the potential for resident abuse and protects the rights of all residents. PROCEDURE: I. Screening A. The organization will screen potential employees for a history of abuse, neglect, or mistreating residents. 1. All potential employees are required to accurately complete an employment application. 2. All potential employees are interviewed by the Department Director or designee to determine appropriateness for performing job duties of desired position. 3. Original licenses or certificates are requested for viewing during an applicant's interview. State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure and certification requirements and to determine if the potential employee is in good standing with the registry. 4. Reference checks (at least two) will be conducted on all candidates for employment prior to hire. 5. All applicants will sign a Sworn Disclosure Statement. 6. All criminal record checks are reviewed for barrier crimes and appropriateness of employment within 30 days of hire."	F 607		
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	F 641		9/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 3 by: Based on information gleamed during a closed record review and staff interviews, the facility staff failed to complete an accurate discharge Minimum Data Set (MDS) assessment for 1 of 22 residents (Resident #27), in the survey sample. The findings included: Resident #27 was originally admitted to the facility 5/24/22 and discharged from the facility to the community 7/2/22. The discharge diagnoses included; right foot cellulites/septic arthritis, osteomyelitis and chronic kidney disease. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. Review of the discharge MDS assessment dated 7/2/22 revealed the resident's discharge was planned (A0310G), and coded return not anticipated (A0310F) to an acute care hospital at (A2100). Resident #27 was selected by the Centers of Medicare and Medicaid Services (CMS) for a discharge to the hospital review but during the record review it was determined the resident wasn't discharged to the hospital. The physician's discharge summary read the resident was discharged from the facility after receiving rehabilitation services to her vacation home in another state and she would receive assistance from her five sons. An interview was conducted	F 641	1. The discharge disposition for Resident #27 was corrected during the onsite survey. 2. An audit will be conducted for all discharges within the past eight weeks to ensure discharge disposition accuracy. 3. The MDS Coordinator was in-serviced on the importance of accurate assessments. 4. The Director of Nursing/designee will audit all discharge disposition coding for accuracy for a period of six weeks to ensure compliance. Audit results and any trends will be reported to the Quality Assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 4 with Registered Nurse #2 on 8/11/22 at approximately 2:30 p.m., in regards to the resident's discharge status. RN #2 stated the resident was discharged to a private home not the hospital on 7/2/22 and she was accompanied from the facility by her husband. An interview was conducted with the MDS Coordinator on 8/11/22 at approximately 3:10 p.m. The MDS Coordinator stated after her review the discharge assessment dated 7/2/22 wasn't coded correctly and the discharge assessment was modified to read discharged to the community. A copy of the modified assessment was provided to the survey team on 8/11/22 at approximately 6:15 p.m. On 8/11/22 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.	F 641		
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	F 849		9/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 5	F 849		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 6	F 849		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 7 (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 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.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 8 (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. (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 staff interview and clinical record review, the facility's staff failed to ensure a resident who had elected hospice services, their written care plan included both the most recent hospice care plan as well as the facility's care plan for 1 of 22 residents (Resident #3), in the survey sample. The findings included: Resident #3 was originally admitted to the facility	F 849	1. The clinical record for Resident #3 was updated to include the current hospice plan of care. 2. All clinical records for those residents receiving hospice care were audited to ensure the most up-to-date information was included. 3. The Director of Nursing/ designee will in-service all current hospice provider representatives as well as the members of the facility interdisciplinary care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 9 1/3/22 and had never been discharged from the facility. The current diagnoses included; Afib, heart failure and stage 4 sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/25/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #3's cognitive abilities for daily decision making were moderately impaired. Review of Resident #3's clinical record revealed she was admitted into hospice services on 4/11/22 for chronic heart failure. A review of the care plan in the clinical record revealed a problem which read; (name of the resident) is receiving hospice care (began 4/11/2022). The goal read; (name of the resident) will receive enhanced services for end of life needs through the review period. The interventions included; activities of daily living (ADL) care will be coordinated with both facility and hospice company, Hospice Nurse to collaborate with primary physician as needed, and facility social services will maintain communication with Hospice point of contact. A further review of the clinical record revealed the hospice agency didn't include their care plan with the facility's care plan, therefore the services to be provided by the hospice agency were not known by the facility staff and the problems and goals the hospice agency were working towards weren't available for the facility staff to be involved in all of the resident's ongoing healthcare needs. An interview was conducted with Registered Nurse (RN) #2 on 8/10/22 at approximately 4:10 p.m. RN #2 stated the hospice agency doesn't provide documents for	F 849	team on the importance of a complete and current clinical record. 4. The Director of Nursing/ designee will audit all clinical records for a period of six weeks for those residents receiving hospice services to ensure compliance. Audit results and any trends will be reported to the Quality Assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 10	F 849		

the individual resident record for they utilized one binder to store records for all residents they serviced in the facility. As the Director of Nursing (DON) looked through the binder which held multiple resident documents she stated the last records available were dated 7/20/22, therefore she telephoned the agency to obtain the most recent documentation.

On 8/11/22, at approximately 11:30 a.m., the DON stated the hospice agency stated the documents were submitted to another email address and that's why they were not available to them her and going forward they would ensure the hospice documents were obtained timely and integrated into the individual resident's record.

On 8/11/26 at approximately 1:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.