STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING ______ B. WING ______	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/20/23 through 06/23/23. The facility was 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	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.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/20/23 through 06/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Thirteen (13) complaints were investigated during the survey: VA00057600-Substantiated, without a deficiency, VA00058768-Substantiated, without deficiency, VA00055488-Substantiated, without a deficiency, VA00055453-Unsubstantiated, lack of sufficient evidence, VA00053178-Unsubstantiated, lack of sufficient evidence, VA00053279-Unsubstantiated, lack of sufficient evidence, VA00055929-Substantiated, without deficiency, VA00054913-Substantiated, without deficiency, VA00057706-Substantiated, with a deficiency, VA00054293-Unsubstantiated, lack of sufficient evidence, VA00052614-Substantiated, without deficiency, VA00058965-Substantiated, without deficiency, VA00059032-Substantiated, without deficiency. The census in this 197 certified bed facility was 113 at the time of the survey. The survey sample consisted of fifty (50) Resident record reviews.	F 000	F 584 1. Resident #273 has discharged from the facility on 6/21/23. The facility was treated for gnats during survey. The facility is treated monthly for pest control and pest control is called for concerns of pest when identified for on call services.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7.13.23

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.

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F 584	Continued From page 1 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	2. A 100% audit of the building has been completed by the Maintenance Director and Administrator to identify visible pest control concerns. All items areas of concerns identified have been documented in the facilities pest control log and the pest control organization has been notified. 3. 100% of all team members have been in serviced regarding pest control and reporting pest sightings by the Facility Educator. The Maintenance Director and Housekeeping Director have been in-serviced by the Administrator regarding pest control. 4. Maintenance Director or designee will conduct weekly inspections for twelve weeks to ensure the facility remains free of gnats and pests. Results of the weekly inspections will be submitted to the QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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F 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and staff interview, the facility staff failed to maintain a clean comfortable homelike environment for 1 of 50 residents (Resident #273), in the survey sample. The findings included: Resident #273 was originally admitted to the facility 6/1/2023 after an acute care hospital stay. The resident discharged from the facility on 6/21/23. The diagnoses included; a urinary tract infection (UTI), status post a kidney transplant and kidney stones. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/2023 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #273's cognitive abilities for daily decision making were intact. On 6/20/23 at approximately 1:53 p.m. an interview was conducted with Resident #273 in her room. The resident was reclined in on her bed, talking about the events which brought her to the facility and the plan for her to be discharged home 6/21/23 at 3:00 p.m. The resident stopped mid-sentence to ask the surveyor if she saw the gnats in her room. The resident stated she needs to drink a lot of water to aid in passing the kidney stones but the gnats go down the straw into her water so she doesn't always have water to drink. Resident #273 also	F 584		

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F 584	Continued From page 3 stated the gnats were in her room when she was admitted to present time. The resident also said when she removes the top from her meal tray she has to fight the gnats off to consume the meal. The resident further stated "what is homelike about that." An interview was conducted with the Director of Maintenance on 6/23/23 at approximately 12:15 p.m. The Director of Maintenance stated they had a problem with gnats but thought it was no longer a concern. He also stated the gnats were associated to the resident having flowers and plants in the facility and he thought if they keep them out the problem would be totally resolved. The Director of Maintenance stated, "I asked the pest control company come in today (6/23/23) because he was asked today about the gnat situation in the facility. The pest control technician used a special aerosol was gnats today and prior to that he believes the special aerosol was used last month." Over the four days of the survey (6/20/23 - 6/23/23) the survey team identified gnats throughout the facility including the conference room. On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. 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 584		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		

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F 602	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, record review, document review and facility policy review, the facility failed to protect seven out of seven residents (Resident (R) 71, R2, R64, R324, R225, R63, R56) reviewed for abuse, specifically the misappropriation of resident's property out of a total sample of 50 residents. This failure has the potential for misappropriation of property for other residents. Findings included: Review of the facility policy, "Virginia Resident Abuse Policy" dated 10/03/2022 (sic), revealed, "Policy: This Facility will not tolerate ... misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of ...misappropriation of resident property ...Procedure: 7) Investigate: Once the Administrator and DON (Director of Nursing) are notified, an investigation of the allegation or suspicion will be conducted ...The person investigating the incident should generally take the following actions: i. Interview the resident, the accused, and all witnesses ... c. Documentation. Evidence of the investigation should be documented. 8) Reach a Conclusion: After	F 602	F 602 1. Residents 71, 2, 64, 63, 56 have had their medications replaced. Residents 324 and 225 have discharged from the facility (3/18/23 and 1/20/23). 2. A 100% audit was performed to ensure no other residents were missing medications. 3. 100% of all licensed nursing staff were educated on controlled medication management from delivery to discontinuation by the Director of Nursing.	

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F 602	Continued From page 5 completion of the investigation, all of the evidence should be analyzed, and the Administrator (or his/her designee) will make a determination regarding whether the allegation or suspicion is substantiated, and, for Injuries of Unknown Source, a determination regarding the probable source of the injury." 1. Review of R71's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R71 was admitted to the facility on 05/06/20 and readmitted on 06/12/20 with diagnoses which included malignant neoplasm of lower lobe right lung, atrial fibrillation (irregular heartbeat), congestive heart failure, vascular dementia, cerebral infarction (stroke). Review of the facility's investigation revealed an unnamed and undated document that indicated R71 was missing 22 oxycodone tablets. Review of R71's EMR under the "Orders" tab revealed a "Physician Order" for oxycodone-acetaminophen tablet 5-325mg (milligram), give 1 tablet by mouth every 12 hours for RA (rheumatoid arthritis) pain, start 07/12/22. 2. Review of R2's undated "Admission Record," located in the EMR under the "Profile" tab revealed R2 was admitted to the facility on 12/13/17 and readmitted on 05/24/23 with diagnoses which included unspecified intestinal obstruction, major depressive disorder, chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity cerebral infarction (stroke). Review of the facility's investigation revealed an	F 602	4. DON or designee will perform audits of how all controlled medications are accounted for from delivery, discontinuation, to destruction 5 times per week to for 12 weeks ensure the policy and procedure is being followed. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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F 602	Continued From page 6 unnamed and undated document that indicated R2 was missing 23 hydrocodone tablets. Review of R2's EMR under the "Orders" tab revealed a "Physician Order" for hydrocodone-acetaminophen tablet 5-325mg, give 1 tablet by mouth every 12 hours as needed for chronic back pain, start 10/17/22. 3. Review of R64's undated "Admission Record," located in the EMR under the "Profile" tab revealed R64 was admitted to the facility on 01/27/21 and readmitted on 09/06/22 with diagnoses which included aphasia (disorder affecting communication) following cerebral infarction (stroke), malignant neoplasm of left breast, epilepsy. Review of the facility's investigation revealed an unnamed and undated document that indicated R64 was missing 9cc (cubic centimeters) liquid morphine. Review of R64's EMR under the "Orders" tab revealed a "Physician Order" for morphine sulfate 100mg CR (prolong release), give 0.5 ml (milliliter) by mouth every 3 hours as needed for pain, give sublingually for moderate to severe pain, start 10/21/22. 4. Review of R324's undated "Admission Record," located in the EMR under the "Profile" tab revealed R324 was admitted to the facility on 04/02/22 and readmitted on 02/08/23 with diagnoses which included acute respiratory failure with hypoxia (in sufficient oxygen levels) tracheostomy, gastrostomy.	F 602		

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F 602	Continued From page 7 Review of the facility's investigation revealed an unnamed and undated document that indicated R324 was missing 275cc liquid oxycodone. Review of R324's EMR under the "Orders" tab revealed a "Physician Order" for oxycodone hcl (hydrochloride) solution 5mg/5ml, give 5ml via PEG (percutaneous endoscopic gastrostomy) tube every 6 hours as needed for pain, start 11/29/22. 5. Review of R225's undated "Admission Record," located in the EMR under the "Profile" tab revealed R225 was admitted to the facility on 12/07/22 and readmitted on 01/18/23 with diagnoses which included congestive heart failure, chronic kidney disease, chronic pain, acute respiratory failure with hypoxia. Review of the facility investigation revealed an unnamed and undated document revealing R225 was missing 10 oxycodone tablets. Further review of R225's EMR under the "Orders" tab revealed R225 was ordered oxycodone-acetaminophen tablet 5-325mg, give 1 tablet by mouth every 4 hours as needed for moderate to severe pain, start 12/07/22. 6. Review of R63's undated "Admission Record," located in the EMR under the "Profile" tab revealed R63 was admitted to the facility on 09/07/19 and readmitted on 02/10/22 with diagnoses which included chronic obstructive pulmonary disease, major depressive disorder, morbid obesity, dementia, asthma, adjustment disorder. Review of the facility's investigation revealed an	F 602		

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F 602	Continued From page 8	F 602		

unnamed and undated document revealing R63 was missing 144 Percocet tablets.

Further review of R63's EMR under the "Orders" tab revealed a "Physician Orders" that indicated Percocet tablet 5-325mg (oxycodone-acetaminophen), give 1 tablet by mouth every 6 hours as needed for pain, start 10/31/22.

7. Review of R56's undated "Admission Record," located in the EMR under the "Profile" tab revealed R56 was admitted to the facility on 12/03/18 with diagnoses which included nontraumatic intracerebral hemorrhage, dementia, congestive heart failure, chronic obstructive pulmonary disease.

Review of the facility" investigation revealed an unnamed and undated document that indicated R56 was missing 102 Percocet tablets.

Further review of R56's EMR under the "Orders" tab revealed R56 was ordered Percocet tablet 5-325mg, give 1 tablet by mouth every 8 hours as needed for jaw pain, start 10/21/21.

In an interview on 06/22/23 at 3:30 PM, the Regional Vice President of Operations (RVPO) stated, "on 01/02/23 a nurse reported a medication card of Percocet (an opioid pain medication) was missing from the medication cart. As a result of this discovery a full facility audit was performed, and additional medications were discovered to be missing. A full investigation was carried out, staff were interviewed, and residents were given head to toe assessments.

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F 602	Continued From page 9 All affected residents were assessed for pain, no residents were found to be in distress or reporting signs or symptoms of pain. No resident was found to have missed any doses of pain medication and the missing medications were replaced. Suspected staff provided written statements and have resigned from the facility. Agency staff suspected have not returned to the facility. The cameras in the facility did not work so there was no video evidence to review. There have been previous incidents of missing medication in the facility and no suspect has been identified after the investigations were completed. The police were notified along with other appropriate agencies. Increased audits of medications are being conducted." Review of the facility incident investigation confirmed the incident occurred.	F 602	F 622 1. Resident 324 has discharged from the facility on 3/18/23. 2. A 100% audit of all residents that have been discharged from 06/23/23 have been audited to ensure they have been given a copy of the care plan prior to discharge. 3. 100% of all licensed nursing staff and Social Services staff have been in-serviced by the Director of Nursing on the requirement to send a copy of the resident's care plan with them prior to discharge. 4. DON and/or designee will conduct audit weekly for 12 weeks to ensure a copy of the resident's care plan is sent with the resident prior to discharge. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 07/17/23.	
F 622 SS=D	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 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;	F 622		

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F 622	Continued From page 10 (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 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	F 622		

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F 622	Continued From page 11 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: 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 goals for 1 of 50 residents (Resident #324) after being transferred and admitted to the hospital on 12/10/22. The findings included: Resident #324 was originally admitted to the	F 622		

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F 622	Continued From page 12	F 622		

nursing facility on 04/02/22. Diagnosis for the resident included but are not limited to Gastrostomy and Trachoestomy.

The most recent Minimum Data Set (MDS - an assessment protocol) a significant change with an Assessment Reference Date (ARD) of 02/23/23 coded Resident #324 with a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.

The Discharge MDS assessments was dated for 12/10/22 - discharge return anticipated. Resident #324 was re-admitted to the nursing facility on 12/22/22.

A review of Resident #324's clinical record indicated the resident was transferred to the local hospital on 12/10/22 related to clogged G-tube.

On 06/23/23 at approximately 12:46 p.m., an interview was conducted with License Practical Nurse (LPN) #6. She stated she sent Resident #324 out to the hospital on 12/10/22 for a clogged G-tube. After the LPN reviewed the resident's clinical record, she stated she would get back to the surveyor related to the resident's care plan being sent upon transfer or shortly after. On the same day at approximately 1:11 p.m., an interview was conducted with the Director of Nursing. She stated LPN #6 informed her she was unable locate in the resident's clinical record that Resident #324's person-centered care plan was sent when discharged and admitted to the hospital on 12/10/22. The DON stated if the resident's clinical record did not indicate the care plan was ever sent when discharge or shortly after, then the care plan was never sent to the

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F 622 Continued From page 13
receiving provider.

On 06/23/23 at 2:06 p.m., the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services Nursing were informed of the above findings. The DON stated the purpose of sending the residents care plan is for the receiving provider to maintain continuity of care.

Definitions
-A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach (https://medlineplus.gov).

-A tracheostomy is surgery to create a hole in your neck that goes into your windpipe. If you need it for just a short time, it will be closed later. Some people need the hole for the rest of their life. The hole is needed when your airway is blocked, or for some conditions that make it hard for you to breathe. You may need a tracheostomy if you are on a breathing machine (ventilator) for a long time; a breathing tube from your mouth is too uncomfortable for a long-term solution. The tracheostomy provides a way for your health care providers to gradually remove the ventilator if possible (https://medlineplus.gov).

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

F 623

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F 623	Continued From page 14 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; (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;	F 623	F 623 1. Resident 102 has been given a written notice of transfer regarding the March 3, 2023 transfer. 2. A 100% audit of all residents that have discharged from the facility since 06/23/23 have been audited to ensure they have been given a written notice of transfer prior to discharge. 3. 100% of all licensed nursing staff have been in-serviced by the Director of Nursing on the requirement to send a written notice of transfer with residents prior to discharge. 4. DON or designee will conduct weekly audits for 12 weeks to ensure a copy of the written notice of transfer is sent with the resident prior to discharge. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 07/17/23.	

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F 623	Continued From page 15 (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 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	F 623		

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F 623	Continued From page 16 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 record review, interview, and facility policy review, the facility failed to provide evidence that one of two residents (Resident (R) 102) reviewed for hospital transfers, out of a total sample of 50 residents, documentation that the resident and/or the resident representative were provided a written notice of transfer when the residents were transferred to the hospital. Findings included: Review of the facility policy "Resident Discharge/Transfer Letter Policy," dated 04/19/2023 (sic), revealed, "Policy: The Facility will complete discharge letters appropriately and according to all federal, state, and local regulations." "Procedure: ...D) Discharge notices must have the following components: 1. The reason for discharge/transfer, to include appropriate verbiage listed above. 2. The effective date of transfer/discharge. 3. The location to which the resident is transferred/discharge, this must be a specific address which has accepted the resident and is an appropriate location. 4. A statement that the resident has the right to appeals the action to the state. 5. The name, address, and telephone number of the Local and State long term care ombudsman.	F 623		

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F 623	Continued From page 17 6. The mailing address and telephone number of agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Assistance and Bill of Rights Act. 7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. E) Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. 1. Copies will be sent to the Department of Health, Ombudsman Office and filed in the business file and/or scanned into the electronic chart with administrator/designee signature, with the certified receipt if applicable. 2. For emergency transfers, one list can be sent to the Ombudsman at the end of the month. F) Social service of designee will document in the chart all discharge/transfer reasons, any notices given to the resident or the guardian/sponsor, and discharge planning." Review of R102's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R102 was admitted to the facility on 10/26/22 and readmitted on 03/08/23 with diagnoses which included acute respiratory failure, anxiety disorder, dependence on respirator (ventilator) status, atrial fibrillation, end stage renal disease, morbid obesity, gastrostomy, tracheostomy status. Review of the EMR "Progress Notes," located under the "Notes" tab, revealed an "Alert note" dated 03/03/23 "While in dialysis, resident voiced	F 623		

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F 623	Continued From page 18 that he was having chest pain and sob [shortness of breath]. Resident was taken back to his room. While transferring resident to his room, resident skin color noted to be pale, and lips were cyanotic ... By the time staff attempted to assist resident with transferring to his bed, Resident became unresponsive ... 911 was called. Resident was transported over to Sentara Leigh (hospital)."Further review of the EMR "Progress Notes" revealed a respiratory therapy note, dated 03/08/23, documented R102 was readmitted to the facility from the hospital. Further review of the record revealed no documentation that written notice of transfer was provided to the resident and/or the resident's representative. In an interview on 06/23/23 at 10:30 AM, the Administrator stated, "Residents and their representatives are only given verbal notifications of resident transfers, and nothing is provided to them in writing."	F 623		
F 625 SS=D	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;	F 625		

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F 625	Continued From page 19 (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. §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, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold policy upon discharge/transfer for 1 of 50 resident's (Resident #324) that was transferred to the local hospital on 12/10/22. The findings included: Resident #324 was originally admitted to the nursing facility on 04/02/22. Diagnosis for the resident included but are not limited to Gastrostomy and Trachoestomy. The most recent Minimum Data Set (MDS - an assessment protocol) a significant change with an Assessment Reference Date (ARD) of 02/23/23 coded Resident #324 with a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The Discharge MDS assessments was dated for	F 625	F 625 1. Resident 324 has discharged from the facility on 3/18/23. 2. 100% of all residents that have discharged from the facility since 06/23/23 have been audited to ensure they have been given a bed hold policy prior to discharge. 3. 100% of all licensed nursing staff have been in-serviced by the Director of Nursing on the requirement to send a copy of the bed hold policy with residents prior to discharge. 4. DON or designee will conduct weekly audits for twelve weeks to ensure a copy of the bed hold policy is sent with the resident prior to discharge. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 07/17/23.	

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F 625	Continued From page 20 12/10/22 - discharge return anticipated. Resident #324 was re-admitted to the nursing facility on 12/22/22. A review of Resident #324's clinical record indicated the resident was transferred to the local hospital on 12/10/22 related to clogged G-tube. On 06/23/23 at approximately 12:46 p.m., an interview was conducted with License Practical Nurse (LPN) #6. She stated she sent Resident #324 out to the hospital on 12/10/22 for a clogged G-tube. After the LPN reviewed the resident's clinical record, she stated she would get back to the surveyor related to the Bed-Hold policy being sent when transferred. On the same day at approximately 1:11 p.m., an interview was conducted with the Director of Nursing. She stated LPN #6 informed her she was unable locate in the resident's clinical record the Bed-Hold Policy was sent when discharged to the hospital on 12/10/22. The DON stated if the resident's clinical record did not indicate the Bed-Hold policy was ever issued to the resident and or their representative on the day of discharge, then the Bed-Hold policy was never provided. On 06/23/23 at 2:06 p.m., the Administrator, Director of Nursing and Regional Director of Clinical Services Nursing were informed of the above findings. No further information was provided prior to exit. The facility policy titled Bed Hold Notice stated the notice is to be provided to the resident and his/her representative at the time of transfer. In the case of an emergency, the paperwork should	F 625		

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F 625	Continued From page 21 be provided within 24 hours. Definitions -A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach (https://medlineplus.gov). -A tracheostomy is surgery to create a hole in your neck that goes into your windpipe. If you need it for just a short time, it will be closed later. Some people need the hole for the rest of their life. The hole is needed when your airway is blocked, or for some conditions that make it hard for you to breathe. You may need a tracheostomy if you are on a breathing machine (ventilator) for a long time; a breathing tube from your mouth is too uncomfortable for a long-term solution. The tracheostomy provides a way for your health care providers to gradually remove the ventilator if possible (https://medlineplus.gov).	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 636		

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Continued From page 22

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or

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1. Resident 41 has had an MDS completed on 06/22/2023.
2. A 100% audit has been conducted to ensure all residents have received a Comprehensive Minimum Data Set assessment every 12 months. All residents identified have been immediately corrected.
3. The MDS coordinator was in-serviced by the Facility Administrator on the requirements of MDS completion including the scheduling and completion of quarterly and comprehensive assessments.
4. The Facility Administrator or designee will conduct weekly audits of scheduled MDS assessments to ensure timely completion of all quarterly and comprehensive assessments for the next twelve weeks. Results of the audit will be submitted to QAPI committee for review and recommendation.
5. Compliance date 07/17/23.

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F 636	Continued From page 23 mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a resident received a comprehensive Minimum Data Set (MDS) assessment not less than once every 12 months, within 366 days for 1 of 50 residents (Resident #41), in the survey sample. The findings included: Resident #41 was originally admitted to the facility 5/120/21 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included a seizure disorder, TBI, schizophrenia disorder, and high blood pressure. The quarterly MDS assessment with an assessment reference date (ARD) of 1/24/23 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 for daily decision making. During a review of the facility task, Resident assessments triggered Resident #41 for not having a Minimum Data Set (MDS) assessment completed for over 120 days. A review of completed MDS assessment for the resident revealed the following quarterly MDS assessments were completed 1/24/23, 10/29/22, 7/29/22 and a comprehensive MDS assessment	F 636		

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F 636	Continued From page 24 was dated 4/28/22 therefore a comprehensive MDS assessment was due April 2023 because each resident must receive a comprehensive Minimum Data Set (MDS) assessment not less than once every 12 months, within 366 days. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a Significant Change in Status Assessment or a Significant Correction to Prior Comprehensive Assessment has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/Care Area Assessment(s)/care plan) depend on the most recent comprehensive and past assessments ' ARDs and completion dates. (CMS's RAI Version 3.0 Manual, Chapter 2 Page 2-21) An interview was conducted with the MDS Coordinator on 6/22/23 at approximately 5:00 p.m. The MDS Coordinator stated after reviewing it was determined that Resident #41's MDS assessment wasn't completed timely and a new MDS assessment had been opened since it was brought to her attention On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. An opportunity was offered to the facility's staff to present additional information, but none was provided, and no other concerns were voiced from them.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 25 §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 information gleamed during the closed record review and staff interview the facility staff failed to complete a Death in Facility tracking record for Resident #47. Resident #47 was originally admitted to the facility 5/22/23 after an acute care hospital stay. The current diagnoses included chronic respiratory failure, a seizure disorder, mini stroke and diabetes. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/28/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #47's cognitive abilities for daily decision making were intact. The closed record was categorized as hospitalization. A review of the discharge MDS revealed it was coded discharged return not anticipated. During the review of the clinical record a nurse's note date 6/12/23 at 4:50 a.m. read, the resident was transferred from the facility to the emergency department of a local hospital. Another nurse's note dated 6/12/23 at 5:31 a.m. read, a nurse telephoned the hospital for information regarding Resident #49 and was told by the hospital personnel that the resident expired at 5:12 a.m., in the emergency department. An interview was conducted with the MDS	F 641	F 641 1. Resident 47 has discharged from the facility. A correct Death in Facility tracking record has been completed on 6/12/23. 2. A 100% audit was conducted for all residents who have discharged since 05/01/2023 to ensure their discharge was coded correctly. This includes any residents who have expired and death in the facility tracking record has been completed. 3. The MDS coordinator has been in-serviced by the Facility Administrator regarding correctly coding discharge MDS assessments. 4. The Facility Administrator or designee will conduct weekly audits of discharged residents for twelve weeks to ensure the MDS is coded correctly. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 07/17/23.	

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Coordinator on 6/22/23 at approximately 5:00 p.m. The MDS Coordinator stated she gained additional information about Resident #47's status and she determined the resident was not admitted to the hospital therefore the Death in facility tracking record should have been completed instead of a discharge assessment return not anticipated.

Death in Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required. (CMS's RAI Version 3.0 Manual, Chapter 2 Page 2-10)

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:
· Temporary home visit of at least one night; or
· Therapeutic leave of at least one night; or
· Hospital observation stay less than 24 hours and the hospital does not admit the resident.
(CMS's RAI Version 3.0 Manual, Chapter 2 Page 2-13)

On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. An opportunity was offered to the facility's staff to present additional information, but none was provided and no concerns were voiced from them.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656	F 656 1. Resident 27 care plan has been updated to ensure it is person centered and includes the resident's seizure disorder. The care plan was updated on 6/27/23. 2. A 100% audit was completed for all residents who have admitted to the facility or readmitted for the past 30 days to ensure all pertinent diagnoses are listed on the care plan with appropriate care measures listed. 3. 100% of all licensed nursing staff have been in-serviced by the Director of Nursing regarding updating care plans to include diagnoses and appropriate care measures upon review of admission diagnosis and readmission diagnosis. 4. DON or designee will conduct weekly audits of all new or readmitted patients to ensure diagnoses and care measures are listed on the care plan for twelve weeks. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, and a clinical record review the facility's staff failed to develop a person-centered comprehensive care plan to include a seizure disorder for 1 of 50 residents (Resident #27), in the survey sample.

The findings included:

Resident #27 was originally admitted to the facility 4/7/23 after an acute care hospital stay. The resident was discharged to a local hospital on 5/30/23 and returned to the facility on 6/8/23. The current diagnoses included chronic respiratory failure, status post a subdural hematoma, a seizure disorder and pressure ulcers.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/13/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were severely impaired.

A review of the clinical record revealed a nurse's noted dated 5/30/23 at 2:26 p.m. It read an order was received from the physician to send Resident #27 to a local emergency room for seizures, altered mental status, a rapid heart rate and fever. The resident's vitals were as follows: blood

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pressure 150/85, heart rate 127, and temperature 100.8. The hospital's discharge summary dated 6/8/23 read the resident had a past medical history significant for a seizure disorder and she was maintained on Keppra (an anticonvulsive). The hospital's discharge summary further read the resident was sent to the emergency room after staff witnessed seizure-like activity at the facility and the emergency room staff noted that she was actively seizing. The resident was treated with intravenous (IV) Ativan and a loading dose Keppra unsuccessfully therefore IV propofol was started with cessation of the seizure activity.

A review of the physician's order summary revealed the resident was receiving Levetiracetam oral Tablet 750 MG (Levetiracetam), give two tablets via G-Tube two times a day for seizures.

A review of the active care plan revealed there was not a seizure disorder care plan to ensure safety during and after seizures, preventing injury, and minimizing the frequency and severity of seizures through appropriate medication management and caregiver education.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 6/22/23 at approximately 1:36 p.m. LPN #1 stated it is the responsibility of the nursing staff to keep each resident's care plan updated and a care plan is necessary to define how to care for the resident.

On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. An opportunity was offered to the facility's staff to

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F 656	Continued From page 30 present additional information, but none was provided and no concerns were voiced from them.	F 656		
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 staff interviews, clinical record review and facility documentation review, the facility staff failed to revise the resident's person-centered	F 657	F 657 1. Resident 75 care pan has been revised to include the right leg immobilizer on 6/23/23. 2. The DON conducted a 100% review of all residents with assistive or adaptive devices and ensured that the devices are listed on the care plan with appropriate care measures. 3. 100% of all nursing staff and MDS coordinator have been in-serviced by the Director of Nursing regarding updating care plans to include adaptive or assistive devices are listed on the care plans with appropriate care measures. 4. DON or designee will conduct weekly audits for twelve weeks of patients with assistive or adaptive equipment to ensure the devices and care measures are on the care plan. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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F 657	Continued From page 31 care plan to include the application and removal of a right leg immobilize for 1 of 50 residents (Resident #75), in the survey sample. The findings included: Resident #75 was originally admitted to the facility 03/29/22. Diagnosis for Resident #75 included but not limited to difficulty in walking and muscle weakness. The most recent Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 05/24/23 coded Resident #75 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. On 06/22/23 at approximately 11:33 a.m., Resident #75 observed sitting in her wheelchair with immobilize to right knee. On the same day at 4:05 p.m., right knee leg brace remained in place. Resident #75 observed sitting in her wheelchair on 06/22/23 at 11:33 a.m., with right knee immobilizer in place. The resident stated she always wears the brace when out of bed. She stated the immobilizer is applied by the Certified Nursing Assistant (CNA), therapy but on occasion, she will apply the knee immobilizer. She stated she has worn a brace since being admitted to the facility in March 2022. A review of Resident #75's care plan did not include the wear of a right leg/knee splint/immobilizer. The Director of Nursing (DON) was interviewed on 06/23/23 at 1:00 p.m. She stated Resident	F 657		

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F 657	Continued From page 32 #75's person-centered care plan should have been revised to include the use of right knee device. On 06/23/23 at 2:06 p.m., the Administrator, Director of Nursing and Regional Director of Clinical Services Nursing were informed of the above findings. No further information was provided prior to exit. The facility policy titled Splint Issuance policy revised 03/11/22. It is the facility's policy that splints shall be issued or fabricated with a provider's order and therapist must evaluate to determine need for splint, fit and issuance. -Procedure: 2. Patient splint schedule will be communicated to the multidisciplinary team and documented in the care plan. Comprehensive Care Planning revised 07/19/19. It is the facility policy for the interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		

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F 690	Continued From page 33 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility's staff failed to ensure appropriate care and services were provided to prevent/reduce complications while utilizing an indwelling catheter for 1 of 50 residents (Resident #27), in the survey sample. The findings included: Resident #27 was originally admitted to the facility 4/7/23 after an acute care hospital stay. The resident was discharged to a local hospital on 5/30/23 and returned to the facility on 6/8/23. The	F 690	F 690 1. Resident 27 indwelling catheter drainage bag has been removed from the floor on6/23/23. 2. The DON conducted an 100% audit of all residents with indwelling foley catheters to ensure appropriate care and services are provided. 3. 100% of all nursing staff were in-serviced by the Director of Nursing on foley catheter care to include proper placement of foley drainage bags to include the bags cannot be resting on the floor. 4. DON or designee with conduct weekly audits of all residents with indwelling foley catheters to ensure proper care and that the drainage bags are not resting on the floor. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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F 690	Continued From page 34 current diagnoses included chronic respiratory failure, status post a subdural hematoma, a seizure disorder and pressure ulcers. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/13/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were severely impaired. In section H0100 of the MDS assessment the resident was coded for utilizing an indwelling catheter. During the tour on 6/20/23 at approximately 1:25 p.m., Resident #27's indwelling catheter's bedside drainage bag was observed resting on the floor, again on 6/21/23 at approximately 12:15 p.m., the indwelling catheter's bedside drainage bag was resting on the floor and on 6/23/23 at approximately 1:35 p.m., an observation was made with Registered Nurse #1 (RN) of Resident #27's indwelling catheter bedside drainage bag resting on the floor. RN #1 donned a pair of gloves, adjusted the bed so the catheter drainage bag was no longer resting on the floor. RN #1 put the drainage bag inside a privacy cover and stated he would educate staff to ensure all catheter drainage bags are emptied prior to weighing the bag down and to make sure the drainage bag didn't rest on the floor. On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. An opportunity was offered to the facility's staff to present additional information and the Director of	F 690		

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F 690	Continued From page 35 Nursing stated they had begun educating the staff regarding best practices when use of an indwelling catheter is necessary. The Centers for Disease Control recommendations to maintain unobstructed urine flow for an individual utilizing an indwelling catheter; Maintain the bag below the level of the bladder. Ensure that the bag is emptied prior to transport. Use a catheter securement device to anchor the catheter. Keep the urine bag off the floor. (https://www.cdc.gov/infectioncontrol/pdf/strive/CAUTI104-508.pdf)	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700	F 700 1. Resident 27 has been reassessed for the appropriate usage of bed rails. The resident's responsible party has been notified of risk and benefits, formal consents have been obtained, and her care plan updated to include the use of bed rails. The bed rails assessment has been completed with appropriate documentation of risks and benefits on 7/12/23. 2. A 100% audit of all residents who have bed rails in use has been completed. All residents identified with bed rails have been re-assessed to ensure the proper installation, review of appropriate alternatives have been completed, consents are on file, and the care plan has been updated.	

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F 700	Continued From page 36	F 700		

and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and clinical record review, the facility staff failed to ensure staff reviewed the risks and benefits of bed rail use with the Resident and/or Resident Representative prior to installation, provide documentation that the facility staff attempted alternatives or that they obtained consent for the use of bed rails prior to use for 1 of 50 residents (Resident #27), in the survey sample.

Findings include:

Resident #27 was originally admitted to the facility 4/7/23 after an acute care hospital stay. The resident was discharged to a local hospital on 5/30/23 and returned to the facility on 6/8/23. The current diagnoses included chronic respiratory failure, status post a subdural hematoma, a seizure disorder and pressure ulcers.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/13/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of two or more people with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing.

During the tour on 6/20/23 at approximately 1:25 p.m., Resident #27 was observed in bed with the head of the bed at approximately 45 degrees,

3. 100% of all Licensed nursing staff have been in-serviced by the Director of Nursing regarding the use of bed rails, ensuring bed rails are on the care plan, the assessments for bed rails is completed and less restrictive measures have proven to be unsuccessful. This education included discussing the risk of bed rails with RP and/or residents.
4. DON or designee will conduct weekly audits of any residents who require or request bed rails to ensure the risk of bed rails are discussed with RP/ resident, the bed rail assessment is completed and the care plan is updated accordingly for twelve weeks. Results of the audit will be submitted to QAPI committee for review and recommendation.
5. Compliance date 7/17/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING ______ B. WING ______	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

(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 700	Continued From page 37 bilateral bed rails were attached to the bed and in an upright position and a fall mat was on the floor on the resident's right side. The resident didn't respond when spoken to and there was no identified body movement. On 6/21/23 at approximately 12:15 p.m., the resident was again observed in bed facing the window, with bilateral bed rails in an upright position. On 6/23/23 at approximately 1:35 p.m., an observation was made with Registered Nurse #1 (RN) of Resident #27 in bed with bed rails were attached to the bed and in an upright position. The active care plan dated 4/25/23 had a problem which read resident has an ADL self care performance deficit related to disease process. The interventions included provide two person staff assistance with repositioning and turning in bed and provide two person assistance with transfers daily. There was not any care plan documentation for use of bed rails. A review of the clinical record failed to reveal an assessment for use of bed rails, neither was there documentation that staff reviewed the risks and benefits of bed rail use with the Resident and/or Resident Representative prior to installation of the bed rails, or documentation that the facility staff attempted alternatives prior to use of bed rails use or that they obtained consent for the use of bed rails prior to use. An interview was conducted with the Director of Nursing on 6/23/23 at approximately 11:40 a.m. The Director of Nursing stated there was not a side rail assessment, risk and benefit information provided to the Resident and/or Resident Representative, or documentation of alternative attempted prior to use of the bed rails and there was not a signed consent for bed rails.	F 700		

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F 700	Continued From page 38 On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. An opportunity was offered to the facility's staff to present additional information. They provided no additional information and voiced no further concerns.	F 700		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and staff interview, the facility staff failed to maintain an effective pest control program so that the facility was free of gnats which was voiced by 1 of 50 residents (Resident #273), in the survey sample. The findings included: Resident #273 was originally admitted to the facility 6/1/2023 after an acute care hospital stay. The resident discharged from the facility on 6/21/23. The diagnoses included; a urinary tract infection (UTI), status post a kidney transplant and kidney stones. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/2023 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This	F 925	F 925 1. Resident #273 has discharged from the facility on 6/21/23. The facility was treated for gnats during survey. The facility is treated monthly for pest control and pest control is called for concerns of pest when identified for on call services. 2. A 100% audit of the building has been completed by the Maintenance Director and Administrator to identify visible pest control concerns. All items areas of concerns identified have been documented in the facilities pest control log and the pest control organization has been notified. 3. 100% of all team members have been in serviced regarding pest control and reporting pest sightings by the Facility Educator. The Maintenance Director and Housekeeping Director have been in-serviced by the Administrator regarding pest control.	

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	495173	A. BUILDING ______ B. WING ______	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 925	Continued From page 39 indicated Resident #273's cognitive abilities for daily decision making were intact. On 6/20/23 at approximately 1:53 p.m. an interview was conducted with Resident #273 in her room. The resident was reclined in on her bed, talking about the events which brought her to the facility and the plan for her to be discharged home 6/21/23 at 3:00 p.m. The resident stopped mid-sentence to ask the surveyor if she saw the gnats in her room. The resident stated she needs to drink a lot of water to aid in passing the kidney stones but the gnats go down the straw into her water so she doesn't always have water to drink. Resident #273 also stated the gnats were in her room when she was admitted to present time. The resident also said when she removes the top from her meal tray she has to fight the gnats off to consume the meal. The resident further stated "what is homelike about that." An interview was conducted with the Director of Maintenance on 6/23/23 at approximately 12:15 p.m. The Director of Maintenance stated they had a problem with gnats but it is no longer a concern. He also stated the gnats were associated to the resident having flowers and plants in the facility and he thinks if they keep them out the problem will be totally resolved. The Director of Maintenance stated, "I asked the pest control company come in today (6/23/23) because he was asked today about the gnat situation in the facility. The pest control technician used a special aerosol was gnats today and prior to that he believes the special aerosol was used last month." Over the four days of the survey (6/20/23 -	F 925	4. Maintenance Director or designee will conduct weekly inspections for twelve weeks to ensure the facility remains free of gnats and pests. Results of the weekly inspections will be submitted to the QAPI committee for review and recommendation. 5. Compliance date 7/17/23.	

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	495173	A. BUILDING ______ B. WING ______	C 06/23/2023

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F 925	Continued From page 40 6/23/23) the survey team identified gnats throughout the facility including the conference room. On 6/23/23 at approximately 2:05 p.m., the above findings were shared with the Administrator, Director of Nursing, a Corporate Consultant, and the Regional Vice President of Operations. 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 925		

State of Virginia

PRINTED: 07/07/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0213	A. BUILDING: ______ B. WING ______	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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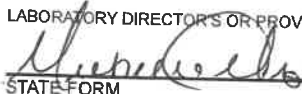
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: An unannounced biennial State Licensure Inspection was conducted 06/20/23 through 06/23/23. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 197 licensed bed facility was 113 at the time of the survey. The survey sample consisted of fifty (50) Resident record reviews. 12VAC 5-37-110 (B) (2) (3). Management and Administration. Cross Reference to F-602. 2VAC 5-371-150 (B.1). Resident Rights. Cross Reference to F-622 and F-625. 12 VAC 5-371-220 (B). Nursing Services. Cross Reference to F-690 and F-700. 12 VAC 5-371-250 (A, C, G). Resident Assessment and Care Planning. Cross reference to F-638, F-641 and F-657. 12 VAC 5-371-370 (E). Maintenance and Housekeeping. Cross Reference to F584 and F-925.	F 001	See F 602 See F 622 See F 625 See F 690 See F 700 See F 638 See F 641 See F 657 See F 584 See F 925 Compliance date 7/17/23	

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



TITLE Administrator

(X6) DATE 7.13.23