STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/21/2023

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SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification / Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification between 07/18/23-07/21/23. The facility was found to be in compliance with 42 CFR 483.73. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/18/23 through 7/21/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Fifteen complaints were investigated during the survey: VA00054348 - Substantiated, without deficiency; VA00049732 - Substantiated, without deficiency; VA00057468 - Substantiated, without deficiency; VA00055266 - Substantiated, with deficiency; VA00056932 - Unsubstantiated, lack of sufficient evidence; VA00057538 - Substantiated, with deficiency; VA00052874 - Substantiated, without deficiency; VA00056441 - Unsubstantiated, lack of sufficient evidence; VA00059078 - Unsubstantiated, lack of sufficient evidence; VA00051508 - Unsubstantiated, lack of sufficient evidence; VA00050387 - Substantiated, with deficiency; VA00053996 - Substantiated, with deficiency; VA00050314 - Substantiated, with deficiency; VA00059046 - Substantiated, with deficiency; VA00050546 - Unsubstantiated, without deficiency.	F 000		

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

Electronically Signed | 08/17/2023

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 000	Continued From page 1 The census in this 169 certified bed facility was 135 at the time of the survey. The survey sample consisted of 59 current and closed reviews.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity by not ensuring the residents' rights to retain personal possessions for two of two sampled residents (Residents (R)52 and R82) reviewed for resident rights. This failure had the possibility to have a negative impact on numerous residents residing in the facility. Findings include: Review of R52's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR) revealed R52 was admitted to the facility on 01/09/19 with diagnoses which included flaccid hemiplegia affecting the left non dominant side, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, heart failure, type II diabetes, major depressive disorder, major depressive disorder, bipolar disorder, aphasia, and anxiety disorder.	F 557	F-557 1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Residents #52 and #82 have had their possessions inventory updated as of 08/14/2023. The laundry staff looked for any missing items. The Activity Director labeled all personal possessions that were suitable to be labeled. If Resident #52 or #82 has continued concerns about missing or damaged clothing the preferred method is the family or resident will replace or repair the item, the check will be made payable to the family member/resident upon proof of sales receipt. On August 18, 2023, the facility	8/31/23

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F 557	Continued From page 2 Review of R52's annual "Minimum Data Set" (MDS) with an "Assessment Reference Date" (ARD) date of 05/31/23, located under the "RAI" tab indicated R52 was extensive assist of one staff member for toileting, supervision of one staff member for bed mobility, independent with transfers and wheelchair mobility, limited assist of one staff member for dressing. The MDS showed Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R52 was cognitively intact. Review of R82's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR) revealed R82 was admitted to the facility on 12/28/21 with diagnoses which included sepsis, muscle weakness, diverticulitis of intestine, type II diabetes, Parkinson's disease, depression, unspecified dementia, and anxiety disorder. Review of R82's quarterly MDS with an ARD date of 05/30/23, located under the "RAI" tab indicated R82 was extensive assist of two staff members with transfers and bed mobility; total dependence of one staff member for toileting; extensive assistance of one staff member for dressing. The MDS showed Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R82 was cognitively intact. During a resident meeting held on 07/20/23 at 10:00 AM, several of the residents (R56, R2, R50, R61, R82, and R52) in attendance stated the facility laundry had not returned some of their clothing items. The residents said their clothing not being returned to them from the laundry had been an ongoing problem. R52 stated he was missing a hat, jacket, and a red, white, and blue	F 557	mailed a letter to residents and responsible parties requesting assistance with labeling and inventorying any items brought into the facility. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. All residents that have a BIMS of 8 or higher will be interviewed regarding their right to retain personal possessions and residents with a BIMS of less than 8 will have a resident representative contacted and interviewed regarding their right to retain personal possessions. The facility will take reasonable steps to protect all personal items brought in by residents or their families and to search to the best of their ability for any lost items. All findings or concerns will be addressed through the grievance process. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? All Staff will be educated on inventory for residents personal possessions. All nursing, laundry, activities, and department managers will be educated on labeling and inventorying residents personal possessions by the Don and/or Administrator. All staff will be educated by the DON and/or Administrator, ADON, SSD, Activity Director, Unit Managers, and Housekeeping Manager, on the Grievance process related to missing	

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F 557	Continued From page 3 blanket. Review of the Resident Council Meeting Minutes, dated for the past year July 2022 through July 2023 indicated there were 10 different residents with complaints of their clothing items not being returned to them from the laundry. R18 stated he did not send his clothes to laundry anymore because he did not get them back. R89 stated she was missing 21 items. R82 stated he was still missing clothes. R61 stated she was missing clothes. R52 stated he was missing jeans and pants and R50 stated was still missing pants. During an interview on 07/19/23 at 11:15 AM, with a laundry employee (LE), she stated finding a good way to mark a resident's clothing had always been an issue. LE said they now have a labeling machine which should fix the problem. LE was not sure what had been put in place to label all residents' clothing. During an interview on 07/19/23 at 1:25 PM, the Assistant Director of Nursing (ADON) stated the facility purchased a labeling machine and have piloted labeling resident's clothing on the third floor. The ADON said prior to the labeling machine they would encourage residents' family members to label a resident's clothing or would write the resident's name on the back of the clothing item with a permanent marker. The ADON stated the Activities Director (AD) has begun to hold a "yard sale" every Friday where she was using the labeling machine to label all the clothing items the residents obtain at the yard sale. During an interview on 07/20/23 at 3:50 PM, with the Activities Director to discuss plan for labeling	F 557	personal possessions. All new stakeholders will be educated in general facility orientation on Resident Rights related to personal possessions and the grievance process. On August 22, 2023, the Ombudsmen will be doing an in-service with facility staff covering Resident Rights. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The Interdisciplinary team will interview 3 residents a week for missing personal items for 12 weeks. Any missing items will be reported to the Administrator through the Grievance process upon notification of the missing item. Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Compliance Date: 08/31/2023	

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F 557	Continued From page 4 Residents' clothing, the AD stated on Fridays after lunch they brought out clothes that have been donated or unclaimed and let residents look them over and choose clothes for themselves. The AD said she had the labeling machine there and labeled the clothes right at that time. The AD stated they have labeled some of the residents' clothes on the 3rd floor. During an interview on 07/21/23 at 10:30 AM, R52 stated that the facility losing some of his clothing was very frustrating for him especially when the items were a connection to his service in the military. During an interview on 07/21/23 at 11:00 AM, R82 stated when his clothing was not returned to him it was like "a burden to me, because I need to get dressed every day."	F 557		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		8/31/23

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F 580	Continued From page 5 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility documentation, the facility staff failed to immediately inform the physician of the need to assess/evaluate, start, or alter treatment when there was a significant deterioration in the resident's condition for 1 of 59 residents	F 580	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #46 was admitted to SNGH on 05/22/2023 with a diagnosis of Subdural	

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F 580	Continued From page 6 (Resident #46) in the survey sample. The findings included: Resident #46 had four (4) falls between 04/24/23 - 05/22/23 and during that time she had behavioral and neurological changes. She was at risk for major injury related to being on an anticoagulation medication (blood thinner), independent with ambulation, and a diagnosis of dementia. The resident was not assessed after significant behavioral and neurological changes were identified. The resident was transferred to the local Emergency Room (ER), and diagnosed with subdural hematoma/hemorrhage. Resident #46 was transferred via 911 (emergent) to the local hospital on 05/22/23 due to acute left-sided weakness and altered mental status following a ground-level fall at the nursing facility. A computerized tomography (CT) scan was done to reveal a subdural hematoma/hemorrhage. On 05/23/23, Resident #46 underwent right burr hole subdural hematoma evacuation with subdural drain placement. Resident #46 was originally admitted to the nursing facility on 05/14/21. Diagnosis for Resident #46 included but was not limited to acute subdural hemorrhage, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of pulmonary embolism (a blood clot in the lungs), and cerebral infarction (stroke). The Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 04/28/23	F 580	Hematoma. Resident #46 was readmitted to Signature Healthcare of Norfolk on 06/01/2023. On 06/15/2023 and 06/20/2023 Resident #46 was evaluated by her physician at the facility and remains a resident at the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing in the facility have the potential to be affected by the alleged deficient Practice. All Current Residents residing in the facility had a nursing assessment for a change of condition completed and a full set of vital signs taken, which included Temperature, Pulse, Respirations, O2 saturation, and Blood pressure to assess for any type of change of condition. This was completed on 7/21/2023. Any residents assessed as having a change of condition had a physician notification. 3.What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The following actions were taken to address the alleged non-compliance: "On 7/21/23 the VPCO educated the facility Department Head Team which included MDS coordinators, Unit Manager, Administrator, RSM, BOM, ABOM, Social Services Director, Staffing Scheduler, Activity Director, Plant Ops Director on resident change of condition and notification of change of conditions.	

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F 580	Continued From page 7 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence on one with bathing, limited assistance of one with personal hygiene, supervised with limited assistance of one with dressing and toilet use, supervisor with one assistance with eating and transfer, and independent with bed mobility, locomotion on/off the unit, walking in room and corridor with a steady gait all the time. The most recent Minimum Data Set (MDS - an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 06/12/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, personal hygiene, and toilet use, and supervision with one assistance with eating for Activities of Daily Living (ADL) care. Under section G0300 (Balance during transitions and walking) was coded gait not steady, only able to stabilize with human assistance. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident at risk for falls related to psychotropic medication use. The goal set for the resident by the staff was that the resident will remain free from injury. Some of the interventions/approaches the staff would use to accomplish this goal are to assist with all transfers and mobility, obtain physical therapy	F 580	"On 7/21/23 the SDC, Unit Manager, MDS Coordinator, VPCO, VP of Regulatory, Administrator, Staffing Scheduler, Social Services Director, RSM, Activity Director, or Social Services Assistant educated all Licensed Nurses on resident change of condition, following up on resident change of conditions that they are informed of by others, on notifying the physician immediately when there is a noted change in condition of a resident. Any licensed staff not educated on 7/21/23 will be educated prior to working their next shift. "On 7/21/23 the SDC, Unit Manager, MDS Coordinator, VPCO, VP of Regulatory, Administrator, Staffing Scheduler, Social Services Director, RSM, Activity Director, or Social Services Assistant educated all non-licensed nursing staff on immediately informing the charge nurse when noting any change in the condition of a resident so the charge nurse can assess the resident and immediately notify the physician. Any Non-licensed nursing staff not educated on 7/21/23 will be educated prior to working their next shift. "On 7/21/23 the SDC, Unit Manager, MDS Coordinator, VPCO, VP of Regulatory, Administrator, Staffing Scheduler, Social Services Director, RSM, Activity Director, Dietary Manager, or Social Services Assistant educated all non-nursing staff regarding the resident change in condition and notification of change of condition. Any non-nursing staff that were not educated on 7/21/23 will be educated before working their next shift. "Starting on 7/21/23, the facility IDT will review progress notes, events, and vital	

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F 580	Continued From page 8 (PT) consult as needed, resident is self-ambulatory and attempt to toilet resident every 2-3 hours and as needed. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident receiving anticoagulant therapy (blood thinner) due to a history of Pulmonary Embolism (PE). The goal set for the resident by the staff was that the resident will have no active bleeding. Some of the interventions/approaches the staff would use to accomplish this goal are to observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae (tiny purple spots under the skin), purpura (rash of purple spots under the skin), ecchymosis (bruising) areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, and epistaxis). A review of Resident #46's Medication Administration Record (MAR) for May 2023 revealed an order to administer Xarelto (blood thinner) 20 mg by mouth daily with dinner (for a history of pulmonary embolism). A nurse's note entered by License Practical Nurse (LPN) #2 on 04/24/23 at 10:47 a.m., documented Resident #46 with swelling and bruising to the left side of the face near the cheek bone. When asked what happened, Resident #46 said she almost fell getting the baby and pointed at the nightstand. The resident denied falling but has a diagnosis of dementia. The nightstand was re-arranged further away from the bed. The physician and Resident Representative (RR) were made aware of the above incident. According to the nurses' note dated 04/25/23 at	F 580	signs daily on current residents daily for any documentation of change in conditions to ensure physician notification was made by the licensed nurse. This will be daily for 2 weeks, then 5 x a week for 2 weeks, then 3x a week for 2 weeks, then monthly for 2 months. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON, ADON, Unit Managers, and nursing supervisors will review all residents for changes in condition daily in clinical AM meetings, daily walking rounds, and staff huddles. The DON, ADON, Unit Managers, and nursing supervisors will validate that any resident with a change in condition has been assessed and the physician or Nurse Practitioner notified of the change in condition through the rounding, huddles, and clinical am meeting review of Matrix care. "Any concerns identified involving a nurse failing to notify a physician or Nurse practitioner will result in performance improvement up to including termination if warranted. "Any concerns with a resident change in a condition requiring an immediate evaluation will be expedited to the medical director for consultation or transferred to the ER for evaluation and assessment of the resident. An Ad Hoc QAPI meeting was held on	

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F 580	Continued From page 9 3:30 a.m., Resident #46 continued with swelling at the left upper cheek area and now to the outer corner of the left eye. On the same day at 2:49 p.m., Resident #46 was observed with a red spot on the sclera (the white outer layer of the eyeball), and swelling and bruising remained on the left side of the face. Further review of the note did not indicate the physician or Nurse Practitioner (NP) was informed related to the red spot observed on the sclera. On 04/28/23 at 8:22 a.m., a nurses' note entered by LPN #8 documented Resident #46 with increased pain in the left eye. The resident was medicated with Motrin (pain medication) with effective results. Further review of the note did not indicate the physician or NP was informed. A review of Resident #46's nurse's notes revealed on 05/10/23 at 1:45 p.m., the resident was observed with increased agitation. She refused her afternoon medications and vital signs. The note also indicated Resident #46's flooded the bathroom in (room #) with tissue paper and storage equipment. On 05/11/23, according to Resident #46's nurses' note, "Resident #46 refused her afternoon medications and vital signs. On the same day, observed with increased agitation. The resident was seen by the Psych Nurse Practitioner (NP). The psych NP note documented resident was being seen today for a follow-up evaluation for a medication check. Resident #46 refusing medication, patient care and not eating. Resident #46 noted with increase paranoia which is something new. New orders were given for Urine Analysis (UA) with Culture and Sensitivity (C&S), Complete Blood Count (CBC) and Basic	F 580	7/21/23 with the Medical Director and Facility QAPI Team to discuss the change of condition and provider notification. The QAPI committee will meet weekly for 4 weeks beginning on 07/21/2023, then monthly for recommendations and further follow-up regarding the above-stated plan. Based upon an evaluation of audits and observations, the QA Committee determined when the facility is in substantial compliance. Audit documentation will continue to be submitted to the QAPI committee for review and to ensure compliance. QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Date of compliance 08/31/23.	

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Metabolic Panel (BMP) in the morning."

The psych NP was interviewed on 07/21/23 at 2:51 p.m. He stated he was asked by nursing to see Resident #46 on 05/11/23 for increased agitation/behaviors. He stated he ordered labs on Resident #46 but it was the responsibility of the resident's primary physician to follow up with any necessary treatment.

On 05/12/23, a change in condition form was completed on Resident #46. The form identified Resident #46 with increased confusion or disorientation and new or worsened delusions or hallucination. Resident #46 observed requiring more assistance with ADL's. The physician was informed of change in condition. Further review of the clinical record did not reveal a MD or NP visit related to change in condition with Resident #46.

A nurses' note entered on 05/14/23 at 8:06 a.m., documented Resident #46 had a fall on the (11-7 shift). At this time, the resident was observed with a limp while dragging her left leg during ambulation. A message was left for the physician but did not indicate the physician returned the call.

On 05/14/23 at 10:17 p.m., it was documented in the nurses' notes Resident #46 noted with increased agitation to noise, tremors, and unsteady gait and required two persons assist with care. Further review of the clinical record did not indicate the physician or NP was notified.

A review of Resident #46's nurses' note dated 05/15/23 at 6:15 p.m., indicated the resident had been found on the floor in her bathroom without pain or discomfort. The note indicated neuro

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checks were within normal limits (WNL).

A nurses' note dated 05/17/23 at 12:58 p.m., documented day three (3) after an unwitnessed fall indicated Resident #46 required max assist of two (2) person assistance with walking. The note documented the resident had been evaluated by therapy and Resident #46 was unaware of her left lower extremity when moving from sit/stand during therapy sessions.

On 07/21/23 at 9:51 a.m., an interview was conducted with the Physical Therapist (PT). He stated Resident #46 was evaluated and picked up by therapy due to requent falls with poor safety awareness. He stated Resident #46 was dragging her left leg; unable to pick that leg up. He stated prior to her falls, Resident #46 was independent with ambulation and did not require an assistance device (walker or wheelchair).

Resident #46 was evaluated by PT on 05/17/23. According to the evaluation, Resident #46 was seen for a significant decline in her functional mobility skills and what appears to be left lower extremity hemiplegia (weakness or partial paralysis on one side of the body.) It was documented the resident was unable to ambulate and required max assistance with transfers. It was also documented Resident #46 required the use of a wheelchair and Pommel seat cushion to reduce her risk of falls.

On 07/21/23 at 4:14 p.m., an interview was conducted with the Director of Nursing (DON) with five (5) other surveyors present. She stated on 05/14/23, when Resident #46 exhibited increased sleeping, reaching for objects, and observed with tremors, the physician should have

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been notified. She stated the resident could be having neurological issues. She stated Resident #46 needed further evaluation and a clinical assessment by the physician or NP, but it didn't happen. The DON stated according to the nurses on 05/16/23, Resident #46 is leaning towards the left side and required assistance with ambulation which is abnormal for her. She stated when the NP was informed on 05/17/23 that Resident #46 noted with an increase in leaning to her left side with weakness, Resident #46 needed to be evaluated. The DON stated according to the resident's clinical record, the physician or NP did not assess Resident #46 from 05/12/23 when she first showed a change in condition to include frequent falls until she was discharged to the hospital on 05/22/23 with a subdural hemorrhage. The DON was asked if the physician or NP should have come to evaluate/assess Resident #46 she replied, "Absolutely." She stated the facility/provider did not do further assessments to determine what the root cause of the change in condition was for Resident #46's.

Resident #46 had an unwitnessed fall in the day room on 05/22/23. She was sent to the local Emergency Room (ER) via 911 emergence for further evaluation. On the same day at 9:50 p.m., the facility received a call from (name of hospital) informing them that Resident #46 was admitted to the Neuro Intensive Care Unit (ICU).

A review of the hospital record revealed Resident #46 presented in the Emergency Room (ER) on 05/22/23 from (name of nursing facility) for further evaluation due to acute left-sided weakness and altered mental status following a ground-level fall at the nursing facility. The note indicated a subdural hemorrhage/hematoma may have been

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the result due to the ground-level fall. Over the past several days, Resident #46 had worsening gait instability and falls, and today observed with weakness in her left arm. The note indicated a computerized tomography (CT) scan was done to reveal a subdural hematoma/hemorrhage. On 05/23/23, Resident #46 underwent right burr hole subdural hematoma evacuation with subdural drain placement. The resident remained in the Neuro Intensive Care Unit (ICU) for close monitoring and subdural drain until 05/25/23.

A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Clinical Operations on 07/21/23 at approximately 5:30 p.m. No further information was provided prior to exit.

Definitions
-Xarelto is used to treat deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in adults. Rivaroxaban is also used to prevent DVT and PE from happening again after initial treatment is completed in adults (https://medlineplus.gov/druginfo/meds).

Subdural hemorrhage
-A subdural hematoma is a type of bleed inside your head. It's a type of bleed that occurs within your skull but outside the actual brain tissue. Other names for subdural hematoma are subdural hemorrhage or intracranial hematoma. More broadly, it is also a type of traumatic brain injury (TBI).

How do subdural hematomas happen?
-Head injuries cause most subdural hematomas.

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If you fall and hit your head or take a blow to the head in a car or bike accident, a sporting activity or have another type of head trauma, you are at risk for developing a subdural hematoma.

Are some people more likely to get a subdural hematoma?
-People who take blood thinners: Blood thinners slow down the clotting process or prevent blood from clotting at all. If blood doesn't clot, bleeding can be severe and long-lasting, even after a relatively minor injury. Being careful when taking blood thinners: Even minor head injuries can cause a subdural hematoma in people who take blood thinners.

What are the symptoms of subdural hematoma?
-Because a subdural hematoma is a type of traumatic brain injury (TBI), they share many symptoms. Symptoms of a subdural hematoma may appear immediately following trauma to the head, or they may develop over time - even weeks to months.

Signs and symptoms of a subdural hematoma include but are not limited to:
-Confusion and drowsiness.
-Slurred speech and changes in vision.
-Dizziness, loss of balance, difficulty walking.
-Weakness on one side of the body.
-Memory loss, disorientation, and personality changes, especially in older adults with chronic subdural hematoma.

Special note about head injury and symptoms in seniors:
-Some of the symptoms of subdural hematoma in older people, like memory loss, confusion, and personality changes, could be mistaken for

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F 580	Continued From page 15 dementia. The older person may not remember hitting their head. Sometimes, people forget because they are disoriented. Other times, the injury was minor and may have occurred weeks before symptoms appeared. They should still see their healthcare provider for evaluation. What are the treatments for subdural hematoma? -Healthcare providers treat larger hematomas with decompression surgery. A surgeon drills one or more holes in the skull to drain the blood. Draining the blood relieves the pressure the blood buildup causes on the brain (https://my.clevelandclinic.org/health/diseases/21183-subdural-hematoma).	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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	F 584		8/31/23

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F 584	Continued From page 16 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interview, the facility staff failed to ensure the sink in Resident #120's room drained after use for 1 of 59 residents (Resident #120), in the survey sample. The findings included: Resident #120 was originally admitted to the facility 3/8/23 after an acute care hospital stay. The resident had never been discharged from the facility. The current diagnoses included; high blood pressure, high cholesterol and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/23 coded the resident as	F 584	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Maintenance ran a snake through Resident #120□s sink on 07/21/2023 and removed the debris clogging the sink. On 08/30/2023, STR Mechanical checked the room 403 sink for proper functioning; the sink was found to be draining properly and efficiently with no issues. 2. All residents have the potential to be affected by the alleged deficient practice. All other residents have the potential to be affected. An audit has been completed by	

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completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #120's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring physical help of one person with bathing, limited assistance of one person with dressing, supervision of one person with transfers, locomotion, toileting, and personal hygiene, independent after set-up with eating and walking, and independent with bed mobility.

On 7/18/23 at approximately 4:35 p.m., during the initial tour the sink in Resident #120's bathroom was observed to be 1/3 full of standing water. An interview was conducted with Resident #120 on 7/18/23 at approximately 4:37 p.m. The resident stated there had been problems with the sink draining completely for many months. The resident also stated the toilet flushes but it is a matter of knowing the "trick" to hold the handled down until all of the waste is gone out of the commode. He further stated the roommate does not understand how to manage the toilet even though he had explained it to him multiple times.

On 7/19/23 at approximately 1:40 p.m., another observation was made of Resident #120's bathroom sink. This time it was 2/3 full with soapy water. Resident #120 stated the roommate left the water running and when he went in, it was almost full.

On 7/20/23 at approximately 11:45 p.m., the sink was again observed in Resident #120's room. It was still approximately 2/3 full with standing water, the pipes under the sink had been taken apart and a bucket had been placed beneath the

maintenance validating all sink drains and not holding standing water. Any findings will be addressed by maintenance and if maintenance is unable to resolve outside plumbing will be contracted to resolve the plumbing issue.

3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?

Education was provided to the maintenance department by the administrator on resourcing outside contractors for maintenance issues that cannot be repaired by in-house maintenance. The Administrator educated all department managers on completing work orders. All staff were educated by department managers on where and how to complete maintenance work orders. All new stakeholders will be educated in general orientation.

4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?

The ambassadors (department managers) will audit 3 rooms a day 3 times a week for 12 weeks validating sinks are draining in their assigned rooms. Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee.

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F 584	Continued From page 18 sink to capture water. An interview was conducted with Resident #120 at approximately 11:46 p.m. The resident stated Maintenance was working on the sink but there was no improvement thus, he had given up on the sink getting repaired to drain completely. On 7/20/23 at approximately 4:00 p.m., an interview was conducted with the Maintenance Assistant. He stated they had did all they knew to do to get the sink in Resident #120's room to drain therefore, he felt it was time to bring in services from the outside. On 7/21/23 at approximately 4:30 p.m., a final interview was conducted with the Administrator, Director of Nursing and Corporate Consultant. They had no further comments and voiced no additional concerns about the non-draining sink in Resident #120's room.	F 584	The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Removal Date: 08/31/2023	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		8/31/23

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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;
(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

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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 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).

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F 623	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure residents received written discharge notices at the time of transfer to the hospital for four (Resident (R)119, R15, R64, and R70) of six residents reviewed for hospitalization. Findings include: Review of the facility's policy titled, "Transfer/Discharge Notice" dated 11/01/22 revealed for the "Emergent Transfers to Acute Care" section, the facility will send a written notice of discharge to the resident and/or resident representative when the resident was transferred/discharged to the hospital. 1. Review of Resident 119's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/16/23 revealed she had a Brief Interview for Mental Status score (BIMS) of 15 out of 15, indicating she was cognitively intact. On 07/18/23 at 1:48 PM, R119 was asked if she was sent to the hospital recently and she stated she had and that she did not get a written transfer. Review of the "Census" tab of Resident 119's electronic medical record (EMR) revealed the resident was discharged with return expected on 04/15/23 and was returned to the facility on 04/19/23. Review of a progress note located in the "Progress Note" tab dated 04/15/23 at 11:00 AM revealed the resident had increased pain in his	F 623	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Residents #119, 15, 64, and 70 had a written discharge notice accompanying them via EMS when discharged to the hospital for an acute evaluation. Residents #119, 15,64, and 70 and their resident representatives when appropriate were notified of the transfers to the hospital verbally. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficit practice and through alterations in processes and in-servicing, the facility will ensure a resident and responsible party is provided with written notice of the reason for transfer. An audit will be completed from 06/01/2023 of all residents transferred or discharged to validate that written notice was given to the resident or resident representative. Any findings will be addressed. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? All licensed nurses have been educated by the DON, ADON, Unit Managers, and	

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F 623	Continued From page 22 distended abdomen. The physician was called, and an order was given to send the resident to the emergency room. Review of progress note located under the "Progress Note" tab note dated 04/15/23 at 11:41 AM revealed the resident left the facility via stretcher. Review of progress note located under the "Progress Note" tab note dated 04/16/23 revealed the resident was admitted to the hospital and the admitting diagnosis was unknown. Review of R119's e EMR revealed no documentation that a written discharge notice was sent to the resident and resident representative. 2. Review of R15's quarterly "MDS" with an ARD of 05/08/23 revealed she had a BIMS score of 10 out of 15 indicating she was moderately cognitively impaired. Review of R15's "MDS" revealed she had a discharge return expected MDS completed on 02/18/23 and an entry MDS dated 02/28/23. On 07/19/23 at 9:02 AM, R15 stated she had gone to the hospital and stayed overnight when she had a port put in her chest. She stated she could not remember if she received a written discharge notice. Review of R15's "Census" tab in the EMR revealed she was discharged return expected on 02/18/23 and returned to the facility on 02/28/23. A nursing progress note under the "Progress	F 623	Nursing Supervisors on transfer packets that have been placed at the nursing stations to include required transfer notices including bed hold policy to be given to residents and mailed by the BOM/ABOM to the resident representative when transferred or discharged from the facility. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON/Designee will review 3 resident transfers a week for 12 weeks to validate the required transfer documentation and notification was provided to the resident and resident representative. Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Alleged compliance Date: 08/31/2023	

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Note" tab dated 02/18/23 at 10:40 PM revealed the resident was ordered to be transported to the hospital and a progress note dated 02/19/23 at 12:48 AM revealed the nurse contacted the emergency department and was told she was being admitted.

3. Review of R64's quarterly "MDS" with an ARD date of 06/30/23 revealed she had a BIMS score of 15 out of 15 indicating she was cognitively intact.

Review of a progress note located under the "Progress Note" tab dated 06/18/23 at 11:38 AM revealed the resident was transported to the hospital due to having her head down with her chin over her open trach and refusing to allow staff to place the trach collar and refusing to allow staff to complete vital signs and care. The note revealed the physician and the resident's representative was called and she was transported to the hospital.

A progress note located under the "Progress Note" tab dated 06/25/25 at 1:32 PM revealed the resident was readmitted to the facility.

Review of R64's "Progress Notes" tab of the EMR revealed she had a nursing note dated 07/13/23 at 12:00 PM revealing she (R64) was observed on the floor. She stated she was attempting to bend over and pick something up off the floor ...The resident communicated via communication board that she had pain in the right knee, and she wanted to go to the hospital. A progress note dated 07/13/23 at 1:00 PM revealed she left for the hospital.

Review of R64's EMR revealed no documentation

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F 623	Continued From page 24	F 623		

that a transfer/discharge notice was sent to the resident and/or resident representative.

On 07/20/23 12:34 PM, the Vice President of Clinical Operations (VPO) verified that there was no documentation for the residents identified that the resident and their representative received a written transfer/discharge notice at the time of the transfers/discharge to the hospital.

On 07/20/23 1:53 PM the VPO stated the facility did not give the resident or resident representative a written discharge/transfer notice. She stated the facility staff only informed the resident and resident representative verbally of the discharges.

4. Review of R70's "Face Sheet" located under the "Profile" tab of the EMR revealed R70 was admitted to the facility on 08/06/20.

Review of R70's quarterly "MDS" with an ARD date of 04/21/23 located under the "RAI" tab indicated R70 had a BIMS score of five out of 15 indicating R70 was severely cognitively impaired.

Review of R70's EMR under the "Progress Notes" tab, dated 03/22/23 revealed, "Resident noted exhibiting behaviors on this shift, resident noted vomiting x [times] 1, Loose watery stools x3, combative with staff and wandering in rooms ...Resident was noted sweating profusely and breathing fast ... writer called 911 due to resident becoming lethargic while pacing towards nurses station and having to be guided to floor to prevent injury ...Resident complied with EMTs [Emergency Medical Technicians] ...Resident's RP ...has been made aware of resident's condition ..."

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F 623	Continued From page 25 Review of the facility's policy titled, "Transfer/Discharge Notice" reviewed 11/01/22 indicated, "Policy Statement The appropriate notice will be provided to the resident and/or resident representative if it is necessary to transfer ...a resident from a facility. Definitions ...Emergent Transfer to Acute Care: Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected ...Facility-Initiated ...Transfer: The facility may decide to ...transfer a resident only for the reasons permitted under applicable federal and state law, which may include the following: Transferred ...for the sake of the resident ...2. In this event, the facility will notify the resident/resident representative in writing of: The reason the facility has initiated the involuntary transfer ...to another legally responsible institution. The effective date of the transfer...The location to which the resident is transferred ..."	F 623		
F 657 SS=E	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.	F 657		8/31/23

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F 657	Continued From page 26 (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 family interview, staff interviews, clinical record review and facility documentation review the facility staff failed to invite 1 out of 50 resident (Resident #46) or their Responsible Representative (RR) to attend their person-centered care plan meeting. The findings included: Resident #46 was originally admitted to the nursing facility on 05/14/21. Diagnosis for Resident #46 included but not limited to acute subdural hemorrhage, dementia with behavioral disturbance and anxiety. The Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 04/28/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.	F 657	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #46 and her representative attended a care conference on 06/13/2023 via conference call. An additional care plan meeting will be held on 08/11/2023 to include the resident representative. Resident number #46 responsible party was invited to the care conference via phone on 8/9/23. In addition, the responsible party was mailed the invitation via UPS overnight mail on 08/09/23. 2. All residents have the potential to be affected by the alleged deficient practice. All current residents will be audited by MDS, DON, and/or designee to ensure the care plan conference was conducted	

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F 657	Continued From page 27 A phone interview was conducted with Resident #46's Responsible Representative (RR) on 07/19/23 at approximately 12:51 p.m. He stated he had never been invited to attend a care plan meeting for Resident #46. An interview was conducted with the Director of Social Services on 07/21/23 at 3:21 p.m. She stated she was not able to locate anywhere in Resident #46's clinical record that the Resident #46 or their RR were provided their care plan invitation invite/letter for the last 12 months or that care plan meetings were held. She stated care plan meetings should be held every quarter but was not sure why care plan meetings were not held for Resident #46. A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing and Vice President of Clinical Operations on 07/21/23 at approximately 5:30 p.m., who were informed of the above findings. No further information was provided prior to exit. The facility's policy titled Comprehensive Care Plan (Last Reviewed: 04/14/21). Guideline: The person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. 3. Each resident has the right to participate in choosing treatment options and will be given the opportunity to participate in the development, review, and revision of their care plan.	F 657	and the resident representative was invited. Any resident not having a care conference will be offered a care conference and an invitation to include the resident representative. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Care conference meetings and invitations education provided by the DON to, the Social Services Director & each department manager responsible for the care conference meeting upon admission, quarterly, annually & with significant change. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON/Designee will review 3 residents a week for 12 weeks to validate that the required care conference was conducted and documentation that the Resident and resident representative were invited to the conference. Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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F 657	Continued From page 28	F 657	Compliance Date: 08/31/2023	
F 660 SS=D	. Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		8/31/23

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(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge

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F 660	Continued From page 30 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on a resident interview, staff interviews, and a clinical record review, the facility staff failed to assist and develop a discharge plan for a resident to make a successful discharge into the community after the initial option failed for 1 of 59 residents (Resident #114), in the survey sample. The findings included: Resident #114 was originally admitted to the facility 11/2/22 and readmitted 4/19/23 after an acute care hospital stay. The current diagnoses included diabetes and bilateral above the knee amputations secondary to peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/2/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #114's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with personal hygiene, dressing and toileting, limited assistance of one person with bed mobility and transfers, independent with locomotion, and independent with eating after set-up.	F 660	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The Social Service Director (SSD) talked with resident #114 on 08/09/2023 and noted Resident representative has not returned his phone calls. The SSD talked with resident #114 to determine his ability to financially cover the cost of an apartment without access to his money. Resident #114 does not have the means to cover the expenses of an apartment without his daughter being involved. The SSD attempted to contact his daughter and noted the daughter did not answer the call. The SSD was unable to leave a message as the voicemail box was full. The SSD mailed a certified letter to the daughter on 08/08/2023 requesting contact with the SSD to assist resident #114 with income verification to complete the application process and relocation to the community. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be	

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F 660	Continued From page 31 On 7/18/23 at approximately 4:40 p.m., an interview was conducted with Resident #114. The resident stated he desired to be discharged to an apartment in the community for which he had an application in his possession. The resident stated he would like assistance to complete the application and to help to determine if there are other resources in the community, he may be eligible to receive. A nurse's note dated 4/24/23 at 1:14 p.m., read the resident's daughter was looking to transition the resident back home with equipment and additional care as needed. The daughter also desired to discuss discharge plans further once rehabilitation services had dates in mind. Another nurse's note dated 5/4/23 at 10:26 a.m., read the resident's daughter stated she did not feel this would be the right time for the resident to return home because there was not a caregiver to be with him in the home during the day/night. The note also indicated the daughter stated that there were not reliable family members outside of herself and her husband to assist in providing his care. A review of the resident's care plan revealed a problem which read, return to Community Referral/Discharge. Resident expressed a desire to return to the community dated 5/01/23 and updated on 6/18/23. The goal read resident/resident representative will have access to necessary services to promote his adjustment to his new living environment post discharge from the skilled nursing facility by 9/15/23. The interventions included resident will discharge home with family/caregiver. Anticipated date of	F 660	affected by the alleged deficit practice and through alterations in processes and in-servicing, the facility will implement an effective discharge planning process and ensure options to the community and any other options are discussed and assistance provided to make a successful discharge. The DON, ADON, SSD, and MDS coordinator have completed an audit of all residents currently requesting discharge to the community to validate that the care plan is developed, and assistance provided. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Systemic change is the Vice President of Clinical Operations has trained the Social Service director and Social Service assistant on discharge planning, discharge care planning, processes, and care conferences. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON/Designee will review 3 residents a week for 12 weeks to validate that residents wishing to discharge to the community have assistance with resources to discharge to the community, a care plan developed, and documentation of resources for a	

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discharge is 5/9/23. There had been no modification of the original discharge plan after the daughter changed her mind.

A further review of the resident's progress notes failed to reveal other options regarding the resident's discharge to the community therefore an interview was conducted with Social Worker (SW) #1 on 7/20/23 at approximately 10:23 a.m. SW #1 confirmed the resident could make a decision to return to the community and she would explore what planning was in place to assist with his preference.

On 7/20/23 at approximately 11:50 a.m., another interview was conducted with SW #1. SW #1 stated she met with the resident, and he expressed his desire to transition back into the community to live independently in a handicapped accessible apartment in a desired location. SW #1 stated the resident came to her office with an application for the apartment complex he was desired, and they telephoned the complex. SW #1 stated they spoke with an apartment complex representative regarding income requirements and the waiting period for an apartment. SW #1 stated she assisted the resident to complete all sections of the application except the income section because the resident and/or the business office did not know or have access to his annual income information. SW #1 stated the Business Office Manager stated the resident's daughter managed his finances. SW #1 stated a message was left for the resident's daughter to verify his annual income and once the information was received the application would be submitted to the apartment complex.

On 7/21/23 at approximately 4:30 p.m., a final

successful discharge.

Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee.

The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.

Alleged compliance Date: 08/31/2023

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F 660	Continued From page 33 interview was conducted with the Administrator, Director of Nursing and two Corporate Consultants. The Administrator stated they were awaiting a return call from the resident's daughter with the necessary information to proceed with submission of his application.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and a clinical record review, the facility staff failed to ensure a dependent resident's activities of daily living (ADL) were completed for 1 of 59 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 7/19/22 and readmitted 1/14/23 after an acute care hospital stay. The current diagnoses included; malnutrition, hyperparathyroidism, and chronic atrial fibrillation. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring	F 677	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 07/20/2023 Resident #1 had staff file and paint her fingernails and wash her hair. On 07/21/2023 Resident #1 verbalized her teeth had been brushed. 2. All residents have the potential to be affected by the alleged deficient practice. All dependent residents have the potential to be affected by the alleged deficit practice and through alterations in processes and in-servicing, the facility provides ADL care to dependent residents. All residents and or responsible parties have been interviewed to determine their preferences/choices regarding nail care, oral care, and hair care. All dependent residents have had	8/31/23

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34 total care of one person with bathing and toileting, extensive assistance of one person with bed mobility, personal hygiene and dressing, and supervision after set-up with eating. The resident did not transfer or walk. On 7/18/23 at approximately 4:55 p.m., during the initial tour Resident #1 was observed in bed with large white flakes throughout her hair and with long yellow fingernails with some jagged edges. An interview was conducted with Resident #1 on 7/18/23 at approximately 4:58 p.m. The resident stated her fingernails were not cared for because she was required to get out of bed and go down stairs to activities in order to have them filed and painted. The resident also stated her teeth were not brushed and cleaned as often as she desired. Observation of her teeth reveal many broken and discolored teeth. An interview was conducted with the Activities Director on 7/19/23 at approximately 2:10 p.m. The Activities Director stated it is not necessary for a resident to come to an activity for nail care for if they are alerted they will come to the resident. On 7/20/23 at approximately 9:55 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #8, CNA #8 stated it is the assigned CNA's responsibility to wash Resident #1's hair using a shower cap in bed and to provide oral care. CNA #8 also stated the resident does not have to go to activities for nail care for it is provided along with ADL care by the assigned CNA. On 7/21/23 at 9:48 a.m., another interview was	F 677	their care plans updated to reflect their preferences and choices with ADLs. Any resident identified as needing ADL care has had ADL care provided. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The DON, ADON, Unit managers, and Nursing supervisors provided education to all nursing staff on ADL care to dependent residents including hair care, nail care, and oral care. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? " The DON/designee will monitor the resident□s showers/ADL care daily utilizing the ADL Care Audit three days a week in clinical morning meetings. Unit Managers will be assigned to follow up with residents that have an indication that the resident has refused his/her shower/bath/Care as validation of the refusal and the DON will randomly audit at least 3 of the validated refusals at least once a week. " The Ambassadors will interview 2 residents three times a week X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks to validate showers/bathing/Care preferences have been completed. "The IDT will report the findings from the interviews/observations of	

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F 677	Continued From page 35 conducted with Resident #1, she stated "They came in last night filed and painted my fingernails, and washed my hair but the nurse had problems combing my hair out in the back because it was and remains matted". Resident #1 stated her teeth were also brushed before breakfast and her mouth was feeling fresh. On 7/21/23 at approximately 4:30 p.m., a final interview was conducted with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON stated the resident's hair had been shampooed and a medicated shampoo, had been ordered as well as a special mouthwash and her nails had been filed and painted, since the concerns had been brought to their attention.	F 677	showers/bathing Q day and the DON/Unit manager will follow up to reschedule any residents that did not receive their scheduled showers/bathing/Care. "The Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Alleged compliance Date: 08/31/2023	
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 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	F 690		8/31/23

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F 690	Continued From page 36 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: The facility staff failed to provide the necessary care and services to monitor, assess and treat one resident timely who presented with sign and symptoms and complications of a Urinary Tract Infection (UTI) for 1 out 59 residents (Resident #46) in the survey sample. The findings included: Resident #46 was originally admitted to the nursing facility on 05/14/21. Diagnosis for Resident #46 included but not limited to acute subdural hemorrhage, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The most recent Minimum Data Set (MDS - an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 06/12/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief	F 690	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? "Resident #46's previous physician on 07/21/23 at 11:13 a.m. stated the UA showed evidence of a UTI and should have been treated. He stated it's normal to treat prophylactically hoping the right medication was picked. He stated when the urine sensitivity report is obtained and if the wrong medication was prescribed, that medication will be discontinued and an antibiotic that is sensitive to the organism growing will be prescribed. On 05/19/23 at 7:22 a.m., the final urine sensitivity report showed the urine organism growing 50,000 (Escherichia coli). The physician was informed with a new order to start Resident #46 on Keflex	

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F 690	Continued From page 37 Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, personal hygiene, and toilet use and supervision with one assist with eating for Activities of Daily Living (ADL) care. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident experiences bladder/bowel incontinence at times due to dementia. The goal set for the resident by the staff was that the resident will maintain current level of bladder/bowel incontinence and remain free from signs/symptoms (s/s) of Urinary Tract Infection (UTI). Some of the interventions/approaches the staff would use to accomplish this goal is to report any signs of UTI (acute confusion, urgency, frequently, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low/back/flank pain, malaise, foul odor, concentrated urine and blood in urine), provide cueing/supervision assistance for toileting as needed and provide incontinence care after incontinent episodes as needed. On 05/11/23, Resident #46 complained of stomach pain and was administered Motrin (pain medication) 400 mg. On the same day, Resident #46 urinated on herself and on the bathroom floor. The urine noted to have a foul odor. Resident also observed with increased agitation. The resident was seen by the psych Nurse Practitioner (NP) on 05/11/23 with new orders to obtain Urine Analysis (UA) with Culture and Sensitivity (C&S), Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) in the morning.	F 690	(antibiotics) 500 mg every 12 hours x 7 days for UTI. 2. All residents have the potential to be affected by the alleged deficient practice. On 07/21/2023 a clinical assessment was performed on current residents to assess for signs and symptoms of a possible condition change which included signs and symptoms of a UTI. Any signs and symptoms were documented, and the physician was notified of the signs and symptoms of the condition change which would include signs and symptoms of a UTI. 3.What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? "Education has been provided to the Licensed Nurses, by the DON/ADON, on physician notification with conditions changes, signs, and symptoms of UTI, following up on ordered labs to ensure they were collected, transported/sent to the lab, and lab results have been obtained and physician notification of lab results has been completed. "Education has been provided to current State Registered Nurse Aides by DON, ADON, Nursing Supervisors, and Unit Managers, on the signs and symptoms of a UTI and the need to report these to a charge nurse with this possible change of condition from the resident□s baseline.	

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F 690	Continued From page 38 The psych NP was interviewed on 07/21/23 at 2:51 p.m. He stated he was asked by nursing to evaluated Resident #46 on 05/11/23 for increased agitation/behaviors. He stated he ordered labs for blood work and a UA/C&S to rule out an UTI. He stated he ordered labs on Resident #46 but it's the responsibility of the resident's primary physician to follow-up with treatment. On 05/12/23, a change in condition form was completed on Resident #46. The form identified Resident #46 with increased confusion or disorientation, new or worsened delusions or hallucination and blood-tinged urine. The physician was informed of change in condition. Further review of the clinical record did not reveal a MD or NP visit related to change in condition with Resident #46. A nurses' notes dated 05/13/23 at 2:05 p.m., revealed Resident #46 observed with intermittent confusion throughout the day. The note indicated lab results for C&S had not been received. The note indicated the physician was notified of Resident #46's intermittent confusion, but he wanted to wait for the final labs (C&S). During the review of Resident #46's nurses' note dated 05/14/23 at 8:23 a.m., indicated the resident was observed lying on the floor in the bathroom with several spots of urine on the floor. Resident #46 had a bowel movement in the commode with blood noted. The note stated hematuria but also document uncertain where the bleeding was coming from. At 12:30 p.m., Resident #46 was administered Motrin 400 mg for complaints of stomach pain. On the same day at 10:17 p.m., Resident observed to have increased agitation to noise, tremors noted, gait	F 690	4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? "Daily in the clinical meeting, Monday through Friday, the IDT will review clinical documentation to be alert for changes in conditions, signs and symptoms of UTI, and orders for labs that have been followed, along with follow-up on lab results, and physician notification. Saturday and Sunday will be reviewed on Monday. This audit will be completed daily Monday through Friday x 4 weeks. "The DON, ADON, Unit Managers, MDS Nurse, Nursing Supervisors, or designee will perform Monday through Friday x 4 weeks; observation of residents for any reported signs and symptoms of a UTI, change of condition is documented and reported to the physician. This will occur 3 x weekly x 4 weeks: then weekly x 4 weeks. "The Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Alleged compliance Date: 08/31/2023	

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F 690	Continued From page 39	F 690		

unsteady and required two (2) persons assist with care. Further review of the clinical record did not reveal a MD/NP visit or assessment.

The nurses' note dated 05/17/23 at 12:58 p.m., indicated the facility was still waiting for the final urine report for the C&S. The note indicated Resident #46 noted to have hematuria with her bowel movement. NP #1 informed Resident #46 observed with increased behaviors, increased leaning to the left side with weakness and the facility was still waiting for the final urine report.

On 05/19/23 at 7:22 a.m., the final urine sensitivity report showed the urine organism growing 50,000 (Escherichia coli). The physician was informed with a new order to start Resident #46 on Keflex (antibiotics) 500 mg every 12 hours x 7 days for UTI.

On 05/20/23 at 6:47 p.m., Resident urinated on self while in the day room. Resident was assisted to the bathroom where she noted to have small amount of hematuria in the commode.

The clinical note indicated on 05/21/23 at 12:07 a.m., Resident #46 had a bowel movement on the toilet with drips of blood noted.

A phone interview was conducted with Resident #46's previous physician on 07/21/23 at 11:13 a.m. The nurses' notes and labs dated from 05/10/23 through 05/22/23 were reviewed with the physician. He was informed of the abnormal urine analysis with hematuria, increased confusion, tremors, and stomach pain. He stated the UA showed evidence of an UTI and should have been treated. He stated it's normal to treat prophylactic hoping the right medication was

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F 690	Continued From page 40	F 690		

picked. He stated when the urine sensitivity report is obtained and if the wrong medication was prescribed, that medication will be discontinued and antibiotic that is sensitive to the organism growing will be prescribed.

A review of Resident #46's clinical note dated 05/17/2023 at 2:35 p.m., revealed the NP #1 was informed Resident #46 continued with signs/symptoms of UTI, with no new orders.

On 07/21/23 at 10:31 a.m., a phone interview was conducted with NP #1. She stated even though the C&S had not returned, the UA noted Resident #46 had a UTI. She stated it is normal to treat the older population if they are showing s/s of a UTI which she did.

On 07/21/23 at 4:14 p.m., an interview was conducted with the Director of Nursing (DON) with five (5) other surveyors present who were informed regarding the above findings. She stated when Resident #46 was observed with increased sleeping, reach for objects, tremors, and hematuria, the physician or NP should have been notified. She stated the resident could have had neurological issues, internal bleeding, or possible UTI. She stated Resident #46 needed further evaluation and a clinical assessment by the physician or NP. She stated according to the clinical note written on 05/15/23, Resident #46 was observed with hematuria, the physician or NP should had been notified. She stated the physician or NP was never giving an opportunity to assess or treat Resident #46 for the change in condition. The DON was asked if Resident #46 was evaluated and assessed by physician or NP from 05/12/23 - 05/22/23, she replied, "No." She was asked if Resident #46 should have been

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F 690	Continued From page 41	F 690		

evaluated related to the continued change in condition, she replied, "Absolutely."

A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing and Vice President of Clinical Operations on 07/21/23 at approximately 5:30 p.m. No further information was provided prior to exit.

McGreers definition of Urinary Tract Infection
-Urinary tract infection includes only symptomatic urinary tract infections. Surveillance for asymptomatic bacteriuria (defined as the presence of a positive urine culture in the absence of new signs and symptoms or UTI) is not recommended, as this represents baseline status for many residents.

Symptomatic urinary tract infection
One of the following criteria must be met: The resident does not have an indwelling urinary catheter and has at least three of the following signs and symptoms:
-Fever (>38ºC) or chills
-New or increased burning pain on urination, frequency or urgency
-May be new or increased incontinence
-New flank or suprapubic pain or tenderness
-Change in character of urine [may be clinical (e.g., bloody urine) or as reported by the laboratory (new pyuria or microscopic hematuria). For laboratory changes a previous urinalysis must have been negative.
-Worsening of mental or functional status

Definitions
-Urinary Tract Infection (UTI) is an infection

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F 690	Continued From page 42 involving any part of the urinary system, including urethra, bladder, ureters, and kidney. ttp://www.cdc.gov/HAI/ca_uti/uti.html). -Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI. http://www.webmd.com/a-to-z-guides/urine-culture). -Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture).	F 690		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure 1 of 59 residents (Resident #236) in the survey sample were free of significant medication errors.	F 760	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #236 was discharged on	8/31/23

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F 760	Continued From page 43 The findings included: The facility staff failed to ensure the significant medication Lopressor (used to treat high blood pressure) 25 mg was administered twice a day to Resident #326 from 11/14/20 through 11/20/20. Resident #236 was admitted to the facility on 11/13/20 and transferred to an acute care setting on 11/24/20. The resident did not return to the nursing facility. Diagnosis included but are not limited to Congestive Heart Failure (CHF) and Hypertension (high blood pressure). Resident #236's Minimum Data Set (MDS - an assessment protocol) an admission assessment with an Assessment Reference Date of 11/17/20 coded Resident #236's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. Resident #236's person-centered care plan created on 11/15/20 and revised on 11/20/20 identified the resident with health-related issues related to cardiovascular, respiratory and diabetes complications. The goal set for the resident by the staff was that the resident will not develop complications. Some of the interventions/approaches the staff would use to accomplish this goal is to start Lopressor 25 mg by mouth twice a day and to administer medication as ordered. A review of Resident #236's hospital discharge summary dated 11/12/20 included an order to administer Metoprolol (Lopressor) 25 mg twice a day for high blood pressure. A review of Resident #236's clinical record to include the Physician Order Summary (POS) and Medication Administration Record (MAR)	F 760	11/24/2020. All residents residing in the facility currently have the potential to be affected. The DON, ADON, Unit Managers, and Nursing Supervisors completed a medication reconciliation of all admissions since 06/1/2023 for medication accuracy. Any discrepancies have been reported to the provider and plan of care revised as necessary. 2. All residents have the potential to be affected by the alleged deficient practice. All residents residing in the facility currently have the potential to be affected. The DON, ADON, Unit Managers, and Nursing Supervisors completed a medication reconciliation of all admissions since 06/1/2023 for medication accuracy. Any discrepancies have been reported to the provider and the plan of care revised as necessary. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? All licensed nurses have been educated by the DON, ADON, Unit managers, and Nursing Supervisors on following physician orders with an emphasis on medication reconciliation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?	

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F 760	Continued From page 44 revealed the medication Lopressor was not started until 11/20/20. The clinical record indicated an Event Detail report dated 11/20/20 indicated a medication error related to Resident #236's high blood pressure medication (Lopressor) was not entered into the system on 11/13/20 indicating Resident #236 missed 13 does of her blood pressure medication. Further review of the Event Detail report documents the physician was made aware with a new order to start Lopressor 25 mg twice a day for high blood pressure. An interview was conducted with the Director of Nursing (DON) who was the MDS Coordinator when the medication error occurred on 11/13/20. She stated she was doing a chart audit review when she compared Resident #236's discharge order with the admission orders and discovered the resident's Lopressor 25 mg twice a day was omitted from the admission orders. She stated she immediately informed the physician on 11/20/20 with a new order to start Lopressor 25 mg twice a day. A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing, Vice President of Operations on 07/21/23 at 5:30 p.m. No further information was provided prior to exit. Definitions: -Congestive Heart Failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath. Certain heart conditions, such as narrowed arteries in the heart (coronary artery disease) or high blood pressure, gradually leave	F 760	"The DON/ADON/Unit manager/Nursing Supervisor will audit all admission orders with another nurse for accurate medication reconciliation weekly for 12 weeks. "The Audits will be provided and reviewed weekly with the QAPI committee for 4 weeks, and then monthly, with revisions as needed to be determined by the QAPI committee. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. Alleged compliance Date: 08/31/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 07/21/2023

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

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F 760	Continued From page 45 the heart too weak or stiff to fill and pump blood properly (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms). -Hypertension is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high (https://medlineplus.gov/ency/article/007365.htm).	F 760		