STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL VIRGINIA BEACH LLC	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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E 0007 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Address patient/client population and determine types of services needed.** Based on record review, and staff interview, the facility staff failed to have documentation of the facility's identified population at risk during an emergency. The findings included: During an interview on [DATE] at 10:47 A.M. with the Administrator and Maintenance Director, they were asked for documentation of the facility's identified population at risk during an emergency and delegation of authority during an emergency. The Administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency, nor did the facility have documentation of delegation of authority during an emergency.
E 0015 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Address subsistence needs for staff and patients.** Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan included policies and procedures for emergency lighting, fire detection, extinguishing, alarm system, sewage and waste disposal. The findings included: During an interview conducted on 3/3/20 at approximately 10:40 a.m. the Administrator stated, they did not have documentation of the facility having policy and procedures in place to address emergency lighting, fire detection, extinguishing, alarm system and alternate energy source to maintain temperatures.
E 0018 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish procedures for tracking staff and patients during an emergency.** Based on record review and staff interview, the facility staff failed to provide documentation for identifying the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency. The findings included: During a review of the facility's emergency preparedness plan on [DATE] at 10:50 A.M. with the Administrator and Maintenance Director, the Administrator was asked to provide documentation that facility staff had been trained on the facility's system to track the location of on-duty staff and sheltered residents who are relocated during an emergency. The Administrator stated, We have not trained our staff nor do we have a tracking system.
E 0020 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish policies and procedures including evacuation.** Based on record review and staff interview, the facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility. The findings included: During an interview on [DATE] at 11:05 A.M. with the Administrator and the Maintenance Director, they were asked for documentation for the safe evacuation from the facility including care for the residents, transportation, identification of evacuation location and alternate means of communication with external resources and staff responsibilities. The Administrator stated she did not have documentation for the safe evacuation from the facility which included care for residents, transportation needs, communication with external resources and staff responsibilities.
E 0023 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish policies and procedures for medical documentation.** Based on record review and staff interview, the facility staff failed to have verification for preserving patient information in the event of an emergency. The findings included: During an interview on [DATE] at 11:10 A.M. with the Administrator and Maintenance Director, they were asked for documentation for preserving patient information and protecting confidentiality of patient information and maintain the availability of resident records. The Administrator stated, she did not have documentation to ensure patient records were secure and readily available to support the continuity of care for residents during an emergency.
E 0026 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish roles under a Waiver declared by secretary.** Based on record review and staff interview, the facility staff failed to have documentation describing the facility's role in providing care at an alternate care site. The findings included: During an interview with the Administrator and the Maintenance Director at 11:12 A.M. on [DATE], the Administrator was asked for documentation describing the facility's role in providing care at an alternate care site. The Administrator stated the she did not have documentation describing the facility's role or the care that would be provided at an alternate care site.
E 0030 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**List the names and contact information of those in the facility.** Based on record review and staff interview, the facility staff failed to have all facility contact information in the communication plan. The findings included: During an interview on [DATE] at 11:14 A.M. with the Administrator and the Maintenance Director, the Administrator was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communication plan did not include the name of all staff and their contact information, nor did the plan include vendors providing services to the facility during an emergency.
E 0032 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide primary/alternate means for communication.** Based on record review and staff interview, the facility staff failed to develop an emergency preparedness communication plan which included alternate means of communication in an emergency. The findings included: During an interview with the administrator on [DATE] at 11:16 A.M. the administrator was asked to see the facility's alternate communication equipment. The administrator stated, the facility had not purchased alternate communication devices. The facility staff failed to have alternate communication equipment.
E 0033 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish methods for sharing information.** Based on record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for sharing information and medical documentation to maintain continuity of care. The findings included: During an interview on [DATE] at 11:18 A.M. with the Administrator and the Maintenance Director they were asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care. The Administrator stated, she did not have documentation for sharing information and medical care needs for residents at an alternate care site. The facility staff failed to have documentation that the communication plan included methods for sharing information and medical care with other health care providers.
E 0034 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide a means of sharing information on occupancy/needs.** Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy

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

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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E 0034 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 1) needs and its ability to provide assistance. The findings included: During an interview on [DATE] at 11:21 A.M. with the Administrator and the Maintenance Director, they were asked for documentation for identifying the needs of the facility, as well as the facility's ability to provide assistance to the Incident Command Center. The Administrator stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance.
E 0036 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish emergency prep training and testing.** Based on record review and staff interview the facility staff failed to have evidence of emergency preparedness training and testing program review. The findings included: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on [DATE] at 11:25 A.M. with the Administrator, she was asked for documentation of the facility's training and testing program and review. The Administrator stated, the facility had not developed a training and testing program.
E 0037 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish staff and initial training requirements.** Based on record review and staff interview, the facility staff failed to maintain documentation of emergency preparedness training. The findings included: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on [DATE] at 11:28 A.M. with the Administrator, she was asked for documentation for training of emergency preparedness policies and procedures for all new and existing staff. The Administrator stated, the facility had not conducted an initial training program for emergency preparedness and did not produce documentation from the previous owners.
E 0039 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Conduct testing and exercise requirements.** Based on record review and staff interview the facility staff failed to have documentation of the facility's emergency preparedness exercise, analysis and response if needed. The findings include: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on [DATE] at 11:31 A.M. with the Administrator, she was asked for documentation of the facility's table top exercise analysis and the revised emergency plan if necessary. The Administrator stated the facility staff did not conduct a table top exercise (since the change of ownership) and did not provide documentation of any exercises.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of facility documentation, the facility staff failed to implement the advance directive policy by not sending a resident's advance directive to the receiving hospital, and/or provide acknowledgement that allowed an opportunity to formulate an advance directive for 3 of 57 residents (#82, #63 and #109) in the survey sample. The findings included: 1. Resident #82 was admitted to the nursing facility on 2/5/18 with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term memory and moderately impaired in the cognitive skills for daily decision making. A copy of the resident's Advance Directive was not sent with the resident when he was transferred to the local hospital on [DATE], 12/26/19 and 1/5/20. The Acute Care Transfer Document form for each of the resident's aforementioned transfers indicated the advance directives (durable power of attorney for health care, living will) to be sent at the time of transfer in addition to advance care orders (POLST, MOLST, POST, others), but they were not checked off as sent. On 3/3/19 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -physician's orders [REDACTED]. directive and she had not been made aware of any other documents that were considered advance directives or where they were located. On 3/5/20 at 1:45 p.m., the Medical Records Director located Resident #82's advance directives on the unit where the resident resided in his hard chart at the nurse's station. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. They shared they were not aware of the mandate to send a copy of the Advance Directive other than the DNR form upon transfer to the hospital. No further information was provided prior to survey exit. The facility's policy and procedure dated 12/2016 indicated the Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. 2. The facility staff failed to provide Resident #63 with an opportunity to formulate an Advance Directive. A review of the clinical records indicated that Resident #63 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the annual Minimum Data Set ((MDS) dated [DATE] assessed this resident as having a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. A review of the clinical records did not indicate Resident #63 was provided an opportunity to formulate an Advance Directive. During an interview with the Social Worker on [DATE] at 2:30 P.M. the Social Worker stated Resident #63 was not provided the opportunity to formulate an Advance Directive. 3. The facility staff failed provide Resident #109 with an opportunity to formulate an Advance Directive. A review of the clinical record indicated that Resident #109 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the Significant Change MDS dated [DATE] assessed this resident as having a BIMS score of 01 which indicated severe cognitive impairment. A review of the clinical records did not indicate this resident was provided an opportunity to formulate an Advance directive. During an interview with the Social Worker on [DATE] at 2:30 P.M. the social worker stated Resident #109 was not provided the opportunity to formulate an Advance Directive.
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 residents (Resident #3 and #87) in the survey sample. The findings included: 1. The facility staff failed to issue a Notice of Medicare Non-Coverage (NOMNC) letter to Resident #3 who was discharged from skilled services with Medicare days remaining. Resident #3 was admitted to the nursing facility on 11/11/19. [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (MDS) a significant change assessment with an Assessment Reference Date (ARD) date of 11/18/19 coded Resident #3 with an 02 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making. On review of the Beneficiary Notification Checklists provided by the facility to surveyor, it was noted that Resident #3 was not listed for having been issued the Notice of Medicare Non-Coverage (NOMNC) letter. The resident had received the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) however, no copies of the (NOMNC) was provided. Resident #3 started a Medicare Part A stay on 10/04/19 and the last covered day of this stay was 12/04/19. Resident #3 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-) and an NOMNC (CMS-). Resident #3 had only used 31 days of her Medicare Part A services. Only a SNF ABN letter was issued. An interview was conducted with the Social Services Director (SSD) on 03/03/20 at approximately 2:00 p.m. The SSD stated, I did not realize they could receive both; an ABN and NOMNC letter. The SSD said she only gave Resident #3 an ABN letter. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to issue a Notice of

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Medicare Non-Coverage (NOMNC) letter to Resident #87 who was discharged from skilled services with Medicare days remaining. Resident #87 was admitted to the nursing facility on 01/19/20. [DIAGNOSES REDACTED]. Resident #87's Minimum Data Set (MDS) a 5-day PPS with an (ARD) date of 01/23/20 coded Resident #87 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. On review of the Beneficiary Notification Checklists provided by the facility to surveyors, it was noted that Resident #87 was not listed for having been issued the Notice of Medicare Non-Coverage (NOMNC) letter. The resident had received the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) however, no copies of the (NOMNC) was provided. Resident #87 started a Medicare Part A stay on 01/19/20, and the last covered day of this stay was 02/11/20. Resident #87 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-) and an NOMNC (CMS-). Resident #87 only used 37 days of her Medicare Part A services. Only an NOMNC was issued. An interview was conducted with the Social Services Director (SSD) on 03/03/20 at approximately 2:00 p.m. The SSD stated, I did not realize they could receive both; an ABN and NOMNC letter. The SSD said she only gave Resident #87 an ABN letter. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations and staff interviews, the facility staff failed to ensure a homelike environment on 3 units. The findings included: During the survey, the baseboard on Units III, IV and V were observed to be missing. The base boards were missing throughout the entire units. During an interview with the Maintenance Director on 03/04/20 at 11:00 a.m. he stated, the facility staff had removed the baseboard last year and had not replaced it. The Administrator was made aware of the findings on 03/04/20 at 3:15 P.M. The Administrator stated the new owners were going to renovate the facility. When asked for a capital improvement plan she was not able to provide one, nor was she able to give a date and time for the improvements. No further information was provided by the facility staff.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and facility document review, the facility staff failed to implement their Abuse Investigation and Reporting Policy after a witnessed allegation of abuse/mistreatment for 1 of 57 Residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #64's most recent comprehensive Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of [DATE]. The Brief Interview for Mental Status (BIMS) for Resident #64 was coded as having short and long term memory recall problems and severely impaired for cognition and daily decision making. On [DATE] at approximately 12:15 P.M. a test tray food cart was followed onto Unit 5, the secured unit. At the first doorway of the dining area of the secure unit CNA (Certified Nursing Assistant) #2 was observed behind Resident #64's wheelchair pushing him with full force under the table and yelling at him Put your legs down. When Resident #64 resisted being pushed up to the table, CNA #2 went to the other side of the table and pushed the table into him. Resident #64 yelled, Stop. CNA #2 then said, Don't you yell at me. There was no other resident at the table and there was also no other staff members in the room at the time of this incident. The Dietary Manager was standing on my left side in the hallway and did hear the incident when asked about it. The Dietary Manager stated, I couldn't see what was happening I just heard her loud tone I thought she was redirecting him. CNA #3 and LPN (Licensed Practical Nurse) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit. On [DATE] at 12:40 P.M. the Administrator was made aware of the above witnessed interaction by the surveyor between CNA #2 and Resident #64 with physical demonstration. The Administrator was told to please provide any documentation to the surveyor of the facility's response to the incident. Prior to leaving the facility on [DATE] at 5:00 P.M. no facility documentation was provided to the surveyor. On [DATE] at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on [DATE] witnessed by this surveyor. The Administrator stated, Give us a minute. On [DATE] at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows: Investigation Regarding: Abuse allegation Date Prepared: [DATE] Prepared By: Name (Administrator) I. Cause to Initiate Investigation: Survey team member (Name) informed Administration that she witnessed (Name) CNA #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to put down your legs:. She states that she overheard the resident say stop and (Name) CNA #2 allegedly stated don't you yell at me. The CNA was placed on administrative suspension pending investigation. II. Investigation: Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file. III. Summary of Investigation: After speaking with the CNA involved in the incident, the staff on the unit, family members and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents. IV. Recommendations: Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines. No FRI was presented at the time the Investigational Summary was given to this surveyor. On [DATE] at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't. The facility policy titled Abuse Prevention Program revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED]. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled Abuse Investigation and Reporting revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Role of the Investigator: e. Interview the resident (as medical appropriate). i. Interview other residents to whom the accused employee provides care or services. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2)

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On [DATE] at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and facility document review the facility staff failed to report an allegation of abuse/mistreatment to the State Survey Agency and Adult Protective Services within the required time frame for 1 of 57 Residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #64's most recent comprehensive Minimum Data Set (MDS) is an annual assessment with an Assessment Reference Date (ARD) of [DATE]. 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The Dietary Manager stated, I couldn't see what was happening I just heard her loud tone I thought she was redirecting him. CNA #3 and LPN (Licensed Practical Nurse) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit. On [DATE] at 12:40 P.M. the Administrator was made aware of the above witnessed interaction by the surveyor between CNA #2 and Resident #64 with physical demonstration. The Administrator was told to please provide any documentation to the surveyor of the facilities response to the incident. Prior to leaving the facility on [DATE] at 5:00 P.M. no facility documentation was provided to the surveyor. On [DATE] at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on [DATE] witnessed by this surveyor. The Administrator stated, Give us a minute. On [DATE] at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows: Investigation Regarding: Abuse allegation Date Prepared: [DATE] Prepared By: Name (Administrator) I. Cause to Initiate Investigation: Survey team member (Name) informed Administration that she witnessed (Name) CNA #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to put down your legs:. She states that she overheard the resident say stop and (Name) CNA #2 allegedly stated don't you yell at me. The CNA was placed on administrative suspension pending investigation. II. Investigation: Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file. III. Summary of Investigation: After speaking with the CNA involved in the incident, the staff on the unit, family members and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents. IV. Recommendations: Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines. No FRI was presented at the time the Investigational Summary was given to this surveyor. On [DATE] at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't The facility policy titled Abuse Prevention Program revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED]. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled Abuse Investigation and Reporting revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On [DATE] at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and facility document review the facility staff failed to thoroughly investigate a witnessed allegation of abuse/mistreatment for 1 of 57 Residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #64's most recent comprehensive Minimum Data Set (MDS) is an Annual Assessment with an Assessment Reference Date (ARD) of [DATE]. The Brief Interview for Mental Status (BIMS) for Resident #64 was coded as having short and long term memory recall problems and severely impaired for cognition and daily decision making. On [DATE] at approximately 12:15 P.M. a test tray food cart was followed onto Unit 5 the secured unit. At the first doorway of the dining area of the secure unit CNA (Certified Nursing Assistant) #2 was observed behind Resident #64's wheelchair pushing him with full force under the table and yelling at him Put your legs down. When the Resident #64 resisted being pushed up to the table, CNA #2 went to the other side of the table and pushed the table into him. Resident #64 yelled, Stop. CNA #2 then said, Don't you yell at me. There was no other resident at the table and there was also no other staff members in the room at the time of this incident. The Dietary Manager was standing on my left side in the hallway and did hear the incident when asked about it. The Dietary Manager stated, I couldn't see what was happening I just heard her loud tone I thought she was redirecting him. CNA #3 and LPN (Licensed Practical Nurse)

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	495150	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit. On [DATE] at 12:40 P.M. the Administrator was made aware of the above witnessed interaction by the surveyor between CNA #2 and Resident #64 with physical demonstration. The Administrator was told to please provide any documentation to the surveyor of the facilities response to the incident. Prior to leaving the facility on [DATE] at 5:00 P.M. no facility documentation was provided to the surveyor. On [DATE] at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on [DATE] witnessed by this surveyor. The Administrator stated, Give us a minute. On [DATE] at approximately 10:30 A.M. an interview was conducted with Resident #64. Resident #64 was asked if anything happen when he was in the dining room for lunch yesterday. Resident stated, She banged my knee, I don't like to be yelled at. Resident #64 was able to verbalize his name, the correct year and who the current President was. On [DATE] at approximately 10:45 A.M. an interview was conducted with the Dietary Manager regarding what he witnessed with Resident #64 in the dining area on [DATE] around 12:15 P.M. The Dietary Manager stated, I did not see anything, I was outside of the room I heard the CNA being loud I thought she was redirecting the resident. I did not hear the actual verbage. I was concentrating on you and focused on getting the temperatures of the test trays. I didn't process the verbage of what I heard. On [DATE] at approximately 10:50 A.M. an interview was conducted with CNA #3 regarding what he witnessed with Resident #64 in the dining area on [DATE] around 12:15 P.M. CNA #3 stated, I didn't see anything prior to passing trays. I was probably gathering other residents. When I was asked about it I thought they were talking about when we were passing trays, I wasn't in the room prior to passing trays. On [DATE] at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows: Investigation Regarding: Abuse allegation Date Prepared: [DATE] Prepared By: Name (Administrator) I. Cause to Initiate Investigation: Survey team member (Name)) informed Administration that she witnessed (Name) CNA #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to put down your legs:. She states that she overheard the resident say stop and (Name) CNA #2 allegedly stated don't you yell at me. The CNA was placed on administrative suspension pending investigation. II. Investigation: Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file. III. Summary of Investigation: After speaking with the CNA involved in the incident, the staff on the unit, family members and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents. IV. Recommendations: Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines. No FRI was presented at the time the Investigational Summary was given to this surveyor. On [DATE] at approximately 11:20 A.M. an interview was conducted with Resident # 20 whom also resides on the secure unit regarding what he witnessed with Resident #64 in the dining area on [DATE] around 12:15 P.M. Resident #20's most recent MDS was reviewed which was an Annual Assessment with an ARD of [DATE]. The BIMS for Resident #20 was a 15 out of a possible 15 indicating that the resident is cognitively intact and capable of daily decision making. Resident #20 stated, I saw (Name) CNA #2 pushing (Name) Resident #64 legs under the table. She was yelling and rough with him. I see that often and it's not good. Resident #20 was asked how seeing that makes him feel. Resident #20 stated, Makes me feel bad because they can't speak for themselves. I was sitting right there I saw it. Resident #20 was asked if any staff had been rough with him or other residents. Resident #20 stated, Yes, a lot of people, but not me I won't let them. Resident #20 was asked if he had ever reported want he has seen. Resident #20 stated, No, I'm to scared to report it. Resident #20 was asked if any staff member has interviewed him yesterday regarding CNA #2 or if he witnessed in the dining area during lunch on [DATE]. Resident #20 stated, No. On [DATE] at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't The facility policy titled Abuse Prevention Program revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED]. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled Abuse Investigation and Reporting revised [DATE] was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Role of the Investigator: e. Interview the resident (as medical appropriate). i. Interview other residents to whom the accused employee provides care or services. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On [DATE] at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. I asked if anyone had interviewed Resident #64 or any other residents on the unit during the investigation. The Regional Director of Operations stated, No, because (Name) Resident #64 has a low BIMS score and is not interviewable as well as the other residents on the locked unit. The Regional Director of Operations was made aware that Resident #20 on the secure unit had a BIMS score of 15 and was cognitively intact. Prior to exit no further information was provided.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to send the comprehensive care plan goals upon transfer to the hospital for 4 out of 57 residents in the survey sample, Residents #119, #53, #82, and #21. The findings included: 1. Resident #119 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #119's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 1/27/20. Resident #119 was coded as being severely impaired in cognitive

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) function on the staff interview for mental status exam. Review of Resident #119's clinical record revealed that he was transferred to the hospital on [DATE] for behaviors. The following was documented: Resident extremely agitated this shift, as exhibited by constantly walking in and out of other resident's room urinating, on their beds, pushing over furniture in the dining room and not responding at all to redirection. This activity culminated in resident becoming physically aggressive, kicking a nursing aide in the stomach when she tried to intervene resident physically threatening another resident. At this point, a nursing manager called 911 and resident was taken by stretcher to (name of hospital) (medical record) were notified of incident. There was no evidence that care plan goals were sent with Resident #119 upon transfer to the hospital. Further review of the clinical record revealed that Resident #119 was not admitted back to the facility due to being a danger to staff and residents. On 3/4/20 at 3:05 p.m. the nurse who transferred Resident #119 out to the hospital on [DATE] was attempted for an interview. She could not be reached. On 3/4/20 at 4:22 p.m., an interview was conducted with the former DON (Director of Nursing) ASM (administrative staff member) #3. When asked when a resident is sent to the hospital what documents were sent upon transfer, ASM #3 stated that she expected staff to send the e-interact transfer form and the bed hold policy. When asked if she expected her nurses to document what items were sent with the resident upon transfer to the hospital, ASM #3 stated that she did. When asked if the e-interact form included the care plan goals, ASM #3 stated, I don't know. When asked if staff were expected to send the care plan or care plan goals upon transfer to the hospital, ASM #3 Not that I am aware of. On 3/4/20 at 4:33 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #7. When asked what documents were sent with residents upon transfer to the hospital, LPN #7 stated that she would send the face sheet, advanced directive, any pertinent laboratory tests, bed hold policy and the e-interact form. When asked if she would send care plan goals or the care plan with the resident upon transfer to the hospital, LPN #7 stated, I have never heard of that. LPN #7 stated that she also never heard of documenting what items were sent with the resident upon transfer to the hospital. Review of Resident #119's e-interact form dated 2/1/2020 did not address care plan goals. On 3/4/20 at 5:00 p.m., ASM (administrative staff member) #1, the Administrator, was made aware of the above concerns. ASM #1 stated that her admission/transfer/discharge policy did not address care plan goals. No further information was provided prior to exit. 2. Resident #53 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #53's most recent MDS (Minimum Data Set) assessment was a Quarterly Review Assessment with an ARD (Assessment Review Date) of 12/30/2019. Resident #53's BIMS (Brief Interview for Mental Status) score was recorded as unobtainable. A review of Resident #53's clinical record revealed, there was no evidence that a Comprehensive Care Plan was sent to the receiving provider during a transfer to the hospital that occurred on, or about, 12/22/2019. An interview with the facility Administrator on [DATE] at approximately 11:00 a.m. regarding procedures to submit the Comprehensive Care Plan to receiving providers upon discharge, responded, No, we don't do that. An interview with the Corporate Staff #2 regarding facility policy on submitting comprehensive care plans upon discharge produced the following response, There is no policy for submitting the care plan upon discharge. These findings were reviewed with the facility Administrator, Director of Nursing, and Corporate Staff during a briefing held on [DATE] at approximately 5:00 p.m. There was no additional information provided. 3. Resident #82 was admitted to the nursing facility on 2/5/18 with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term memory and moderately impaired in the cognitive skills for daily decision making. A copy of the resident's comprehensive care plan goals was not sent with the resident when he was transferred to the local hospital on [DATE], 12/26/19 and 1/5/20. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -physician's orders [REDACTED].#7 stated she was never told to send anything with the patient or forward to the provider other that the aforementioned documents and never heard of a care plan summary and what it entails. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. They shared they were not aware of the mandate to send or fax a summary of the care plan goals to the transferring entity when residents are transferred from the facility. They stated they did not have a policy or procedure that outlined the directive. No further information was provided prior to survey exit. 4. Resident #21 was re-admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #21 was admitted to the hospital on [DATE]. A review of the Re-admit Minimum Data Set ((MDS) dated [DATE] assessed this resident in the area of Cognitive Patterns - Brief Interview for Mental Status (BIMS) as a 15 which indicated intact cognition. A review of the clinical records did not indicate a Care Plan Summary was sent to the hospital with Resident #21. During an interview on 03/05/20 at 11:00 A.M. with the Administrator, she stated care plans were not sent to the hospital with Resident #21 during his admission (to the hospital) on 11/2[DATE]9.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to issue a bedhold notice to the resident or resident representative at time of transfer to the hospital for 3 of 57 Residents (#89, #82 and #21) in the survey sample. The findings include: 1. The facility staff failed to ensure Resident #89 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on [DATE]. Resident #89 was admitted to the nursing facility on 7/12/18 with [DIAGNOSES REDACTED]. The resident was readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] was a significant change is status and coded the resident with moderate difficulty in hearing, usually has the ability to express ideas and wants and usually comprehends most conversation. Resident #89 was coded on this assessment as having short and long term memory and never/rarely made decisions. The nurse's notes dated 1/14/20 indicated the resident was sent to the local hospital and admitted with a [DIAGNOSES REDACTED]. The resident was readmitted to the nursing facility on 1/19/20. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -physician's orders [REDACTED].#7 stated she does not issue the bedhold policy to the resident or their families, but gave the bedhold notice to 911 or regular transportation. She stated, Maybe they give the bedhold notice to the resident and/or family. The facility's policy and procedures titled Bed-Holds and Returns dated 3/2017 indicated prior to transfer, written information will be given to the residents and the resident's representatives that explains in detail the rights and limitation of the resident regarding bed-holds, reserve bed payment, [MEDICATION NAME] rate and details of the transfer. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit. 2. The facility staff failed to ensure Resident #82 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on [DATE], 12/26/19 and 1/5/20. Resident #82 was admitted to the nursing facility on 2/5/18 with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term memory and moderately impaired in the cognitive skills for daily decision making. The nurse's notes dated 6/2/19 with readmission to the facility on [DATE]; the nurse's notes dated 12/26/19 with readmission on 12/26/19, and nurse's notes dated 1/5/20 with readmission on 1/6/20 did not reference documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -physician's orders [REDACTED].#7 stated she does not issue the bedhold policy to the resident or their families, but gave the bedhold notice to 911 or regular transportation. She stated, Maybe they give the bedhold notice to the resident and/or family. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) information was provided prior to survey exit. 3. The facility staff failed to provide Resident #21 with a bed hold notice upon discharge to the hospital. Resident #21 was discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. Resident #21 was admitted to the hospital on [DATE]. A review of the re-admission Minimum Data Set ((MDS) dated [DATE] assessed this resident in the area of Cognitive Patterns - Brief Interview for Mental Status (BIMS) as a 15 which indicated intact cognition. A review of the clinical records did not indicate a bed hold notice was provided to Resident #21 upon his discharge to the hospital on [DATE]. During an interview on 03/05/20 at 11:00 A.M. with the Administrator she stated, Resident #21 was not provided a bed hold notice upon discharge to the hospital on [DATE].
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to ensure a discharge assessment (MDS) was submitted for 2 of 57 residents (Residents #91 and Resident #1), in the survey sample. The findings included: 1. The facility staff failed to complete a discharge MDS assessment for Resident #91. Resident #91 was admitted to the nursing facility on 01/22/20. Resident #91 was discharged from the facility to home on 02/07/20. [DIAGNOSES REDACTED]. Resident #91's last Minimum Data Set (MDS), an Admission Assessment with an Assessment Reference Date of 01/27/20 coded Resident #91's Brief Interview for Mental Status (BIMS) scoring a 09 out of a possible 15 indicating moderately impaired cognitive skills for daily decision-making. Review of Resident #91's clinical note dated 02/07/20 read in part: Resident discharged from facility at 3:00 p.m. An interview was conducted with Licensed Practical Nurse (LPN) #2 (Assistant MDS Coordinator) on [DATE] at approximately 3:25 p.m. She reviewed Resident #91's clinical record then stated, Resident #91 was discharged home on[DATE]. She said a discharge MDS was not completed. The MDS Coordinator said a discharge MDS should have been completed within 14 days after Resident #91's discharge from the facility. A briefing was held with the Administrator and Director of Nursing on [DATE] at approximately 4:00 p.m. The facility did not present any further information about the findings. CMS' RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI). -Discharge Assessment-return not anticipated: Must be completed when the resident is discharge from the facility and the resident is not expected to return to the facility within 30 days. -Must be completed (Item Z0500B) within 14 days after the discharge date (A200 + 14 calendar days). -Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). 2. Resident #1 was admitted to the facility 6/25/18, and was discharged from the facility to the hospital 10/21/19. The last assessment accepted into the MDS databank was a quarterly assessment dated [DATE]. Review of the clinical record revealed a nurse's note dated 10/21/19 which stated the resident was sent to a local emergency room for evaluation. An interview was conducted with the MDS Coordinator on 3/4/20, at approximately 11:30 a.m. The MDS Coordinator stated the resident's discharge MDS assessment wasn't completed and transmitted to CMS. The MDS Coordinator present a completed discharge MDS assessment on 3/4/20 at approximately 2:15 p.m., along with a validation report indicating the MDS assessment was transmitted to the CMS data bank. On 3/5/19, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and the Regional Director of Operations. The Administrator stated no addition information would be provided.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 57 residents (Resident #76), in the survey sample. The findings included; Resident #76 was originally admitted to the facility 11/7/19 and has never been discharged from the facility. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/19/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of 15. This indicated the resident was with severely impaired daily decision making abilities. In section O0100k2of the 12/12/18 MDS assessment, the resident was coded for hospice care while a resident. Review of the physician order summary revealed no physician's order for hospice care, nor did the active care plan revel hospice services. On 3/2/20 at approximately 11:00 a.m., Licensed Practical Nurse (LPN) #3 was asked which days the hospice staff visited Resident #76. LPN #3 stated she wasn't aware the resident received hospice services but she would review the record for information. LPN #3 stated there was no orders or information in Resident #76's record indicating hospice services. An interview was conducted with the Social Service Director (SSD) on 3/4/20 at approximately 1:35 p.m., the SSD stated upon admission to the facility the resident's daughter stated the resident was admitted to hospice services and would resume the services but later the hospice agency stated Resident #76 didn't qualify at the time for hospice services but they would periodically re-evaluate the resident to determine if she qualified. An interview was conducted with the MDS Coordinator on 3/[DATE]9 at approximately 11:30 a.m., the MDS Coordinator stated the 11/7/18, MDS assessment should not have been coded for hospice care because the hospice agency didn't pick the resident up for hospice services. At approximately 4:35 p.m., the MDS Coordinator stated a modification was made to the 11/7/19, MDS assessment and presented a copy of the modified assessment. On 3/5/20, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Director of Operations. The Administrator stated she understood the concern and had no additional information the offer.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation review, the facility staff failed to develop a person centered care plan to include depression and anxiety for 1 of 57 residents in the survey sample, Resident #100. The findings included: Resident #100 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #100's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/04/2020 coded Resident #100 with short-term memory problems, long-term memory problems, and with severely impaired cognitive skills for daily decision making. Review of Resident #100's clinical record on 03/04/2020 revealed the following: The Medication Administration Record [REDACTED]. Start Date: 08/28/2019 and [MEDICATION NAME] (used for the treatment of [REDACTED]. The MAR indicated [REDACTED]=Music; 2=low stern activity; 3=Relaxation every 8 hours as needed for Behavior Monitoring. Start Date: 01/08/2020. Review of Order Summary Report Dated with Active Orders As Of: 3/04/2020 revealed the following: Document on behaviors, how long it last, any intervention pharmical (sic) or non pharmical (sic) and was it effective. Notify MD every shift Order Date: [DATE] Start Date: [DATE] (Name Psychological Services) May Provide Psychological Services / Med Management Associates to Provide Psychiatric Services Order Date: 02/21/2020 Review of Nurse Practitioner Notes dated 02/24/2020 revealed and is documented in part, as follows: He had significant anxiety during today's exam and was holding his breath during auscultation. Staff stated he does often as a coping mechanism for his anxiety., but it is interfering with his ADL's (Activities of Daily Living). He is on [MEDICATION NAME] and [MEDICATION NAME] as well as [MEDICATION NAME] for depression. A referral to the psych nurse to manage his anxiety was ordered. Review of Resident #100's comprehensive care plan on 03/04/2020 did not include a care plan for depression or anxiety. On 03/05/2020 at 11:15 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #2, the MDS Coordinator, when asked if Resident #100 had a [DIAGNOSES REDACTED].#2 stated, Yes. When asked if the [DIAGNOSES REDACTED].#2 stated, No, it probably should have been. May have been left off, we have been changing things over. When asked if the care plan had been reviewed since change over, LPN #2 stated, Yes. LPN #2 stated, I will add it to the care plan. When asked what is the purpose of the care plan, LPN #2 stated, It's to help us take care of the resident. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. When asked what her expectations were, Director of Nursing stated, Yes, depression and anxiety should have been addressed individually in the care plan. No further information was presented about the finding. The facility policy titled Care Planning, Care Plan Updated - InterdisciplinaryTeam Policy Statement: Our facility's Updating Care Plan/Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan/Updating for each resident.

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	495150	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review staff interview and review of facility documentation, the facility staff failed to revise the care plan for 1 of 57 residents (Resident #96) in the survey sample. The findings include: Resident #96 was admitted to the nursing facility on 7/12/18 with [DIAGNOSES REDACTED]. The resident was readmitted on [DATE] with [DIAGNOSES REDACTED].*meniere's disease and urinary tract infection [MEDICAL CONDITION]. The most recent Minimum Data Set (MDS) assessment dated [DATE] was a significant change is status and coded Resident #96 was coded on this assessment as having short and long term memory and never/rarely made decisions. Resident #96 was coded to need assistance with personal care. This assessment indicated the resident had no significant weight loss or gain. Significant weight loss is a loss of 5% or more in the last month or a loss of 10% in the last 6 months. Significant weight gain is a gain of 5% or more in the last month or 10% or more in the last 6 months. The height of the resident was coded as 49 inches (4 feet and 1 inch) and weight 120 lb (pounds). The resident was coded to be on a mechanically altered therapeutic diet. The Care Area Assessment (CAA) dated 2/5/20 identified nutritional status as a care area that was triggered with a decision to care plan the area. The aforementioned care plan was not revised to reflect the physician prescribed diet order change dated 2/14/20 of NAS (no added salt) diet pureed texture, regular/thin consistency liquids. On 3/4/20 at 10:00 a.m., and interview was conducted with the Minimum Data Set (MDS) coordinator. She stated although it is an interdisciplinary approach, the MDS Coordinator usually enters updates to the care plan, as she should have to reflect any changes in the resident's diet and just missed it. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit. The facility's policy and procedures titled Care planning, Care Plan Updated-Interdisciplinary Team dated 9/2013 indicated the facility's updating care plan/care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan/updating for each resident. The policy and procedure titled Resident Nutrition Services dated 7/2017 indicated that the multidisciplinary staff, including the nursing staff, the attending physician and the dietician will assess each resident's nutritional need, food likes, dislikes and eating habits. They will develop and revise a resident care plan based on this assessment. *People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely unable to swallow or may have trouble safely swallowing liquids, foods, or saliva(https://www.nidcd.nih.gov/health/dysphagia#1). *Meniere's disease is a disorder of the inner ear that can lead to dizzy spells ([MEDICAL CONDITION]) and hearing loss. In most cases, Meniere's disease affects only one ear (https://www.mayoclinic.org/diseases-conditions/meniere's-disease/symptoms-causes/syc- 910).
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility staff failed to provide supervision for one resident (Resident #167) in the survey sample of 57 to prevent an elopement. The findings included: Resident #167 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #167 eloped from the facility on 12/23/19. A Quarterly Minimum Data Set ((MDS) dated [DATE] assessed this resident in the area of Cognitive Patterns -Brief Interview for Mental Status as a 7 which indicated severe cognitive impairment. In the area of Behaviors this resident was assessed as having behaviors for rejecting care. As well as other behavioral symptoms including pacing. In the area of Activities of Daily Living (ADL) this resident was assessed as requiring limited assistance with one person physical assist with transfer, dressing, and eating. A care plan revision dated 12/21/19 indicated: Focus- The resident has a behavior problem. Resident was chasing and yelling at nurses stating I'M going to kill you ___. Goal- The resident will have no evidence of behavior problems. Interventions- Assist the resident to develop more appropriate methods of coping and interacting. Observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. A wandering assessment dated [DATE] indicated: Family requested a wander assessment. The assessment indicated- Significant Change in Condition. Mental Status- Can follow instructions. Mobility- Is ambulatory. History of Wandering -Has a history of wandering (past hospitalization or history from resident/family). Comments/Notes - Resident stated to RP (Responsible Party) that once he got the strength he was going to leave and wasn't staying on the unit. Scoring (7) Low Risk. A 12/21/19 Nursing note indicated: Resident was very combative with the nursing staff chasing the nurses around the unit say (sic) I am going to kill you ___ it had gotten so bad the police was call (sic), he calm down when he saw the police and took all med, now resting in his room. Resident RP was call (sic) left a message to call back when she get the message. MD was notify (sic). A 12/23/19 (08:45) Nursing note indicated: Resident wandered outside of facility this shift and picked up by (Name of Ambulance Service) accompanied by an unknown woman, resident taken to local hospital for evaluation and treatment. An Investigation Summary For Resident #167 included: Event: Elopement [DATE]19 Date- Monday, December 23, 2019 approximately 0530. Resident was noted not to be in his room around 5:30 A.M. on 12/23/19 when CNA (certified nursing assistant) entered to provide care. Facility activated missing resident protocol and began to search the grounds. Facility staff called (DON) Director of Nursing and Administrator regarding the incident. Upon calling 911, the facility staff were informed another call had just come in and the description matched that provided for resident and stated, local EMS was in route to location. Local EMS called facility at 6:45 A.M. and asked which hospital to take resident to for evaluation and then transported to local hospital. DON spoke to hospital staff who reported that resident was doing fine just a little cold, and that they were running some tests to make sure nothing was bothering him. Resident returned to facility in early afternoon at his baseline with no noted injury and was placed on secured unit. DON and Administrator met with resident RP to discuss incident, facility investigation in progress, and previous elopement assessment. Resident left the facility without knowledge of the staff, and the MD and RP were notified of the elopement. The resident was not on the low stem secured unit and not wearing a wander guard as resident had an elopement assessment on 10/09/19 at family request that produced 7.0 low risk. Resident had no changes in status since last 10/09/2019 (name) wandering assessment was completed. The facility elopement policy was re-educated to staff along with staff education to lock front doors. Facility maintenance staff ensured door bell was in place and functioning. maintenance further assessed the locks on the front doors and they were found to be functioning correctly. During an Interview with the Administrator on 03/05/20 at 10:30 A.M. she stated, Resident #167 eloped from the facility. He did not have a wander guard at the time. All doors to the facility were to be locked at night. The Administrator stated, all staff were re-educated on residents who wander and possibly elope. Interviews were attempted with that staff on duty the night of the occurrence however the on duty certified nursing assistant and LPN were called several times but did not answer or return the call.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on staff interview and information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week potentially affecting all residents in the facility. The findings included: During the nursing staff review for July 4, 2019 through March 1, 2020 the facility staff was unable to provide nurse staffing documentation for July 4, 2019 through October 6, 2019. Nurse staffing for October 12, 2019 through March 1, 2010 revealed there were not RN presence in the facility for at least 8 consecutive hours on 10/5/19, 10/19/19, 10/20/19, 10/31/19, 11/3/19, 11/9/19, 11/10/19, 11/16/19, 11/17/19, 11/28/19, 11/29/19, 11/30/19, 12/1/19, 12/7/19, 12/8/19, [DATE], 12/21/19, 12/22/19, 12/23/19, 12/2[DATE]9, 12/25/19, 12/26/19, 12/28/19, 12/31/19, 1/1//20, [DATE], 1/18/20, 1/19/20, 1/25/20, 1/26/20, 2/1/20, 2/2/20, 2/8/20, and 2/28/20. On 3/5/20 at approximately 3:50 p.m., the Staffing Coordinator was interviewed. The staffing coordinator stated she wasn't employed by the facility for all the requested dates and the staffing system was managed differently therefore; she couldn't verify the

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F 0727 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) requested staffing. On 3/5/20, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Director of Operations. The Administrator stated she understood the concern and had no additional information the offer.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an accurate record of controlled medications for 4 of 57 residents (Residents #22, #37, #168 and #418), in a survey sample. The findings included: 1. The facility staff failed to ensure an accurate account of controlled medication for Resident #22. Resident #22 was admitted to the nursing facility on 05/23/19. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 11:52 a.m., an inventory of controlled medication was conducted on the medication cart on Unit 1 with Licensed Practical Nurse (LPN) #2. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #22's, [MEDICATION NAME] 1 mg count per record=23, actual count=22. On 03/02/20 at approximately 11:55 a.m., an interview was conducted with LPN #2 who stated, I did not give Resident #22 her morning [MEDICATION NAME]. She (LPN) said I retrieved the medication cart keys from Registered Nurse (RN)#1 this morning but we never did not do a narcotic count; that was my mistake; we should have counted. An interview was conducted with RN #1 on 03/02/20 at approximately 1:15 p.m. The RN said I should have counted with LPN #2 but it actually slipped my mind. Review of Resident #22's February 2020 Physician order [REDACTED]. On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct. 2. The facility staff failed to ensure an accurate account of controlled medications for Resident #37. Resident #37 was originally admitted to the nursing facility on 05/05/16. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 12:45 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 3 with Licensed Practical Nurse (LPN) #4. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #37's, [MEDICATION NAME] 0.5 mg count per record=27, actual count=26. On 03/02/20 at approximately 12:45 p.m., an interview was conducted with LPN #4. LPN #4 said I gave Resident #37 her morning [MEDICATION NAME]. She said she should have signed the narcotic count sheet right away but was still getting used to the residents here. The LPN stated, I know the correct way to sign off narcotics but I'm still trying to get it together. Review of Resident #37's February 2020 Physician order [REDACTED]. On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct. 3. The facility staff failed to ensure an accurate account of controlled medications for Resident #168. Resident #168 was admitted to the nursing facility on 02/24/20. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 1:05 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 5 with Licensed Practical Nurse (LPN) #5. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #168's, [MEDICATION NAME] 0.5 mg count per record=11, actual count=10. On 03/02/20 at approximately 1:05 p.m., an interview was conducted with LPN #5. LPN stated, I forgot to sign off on Resident #168's 9:00 a.m., [MEDICATION NAME]. She said I should have signed off once I removed the medication from the card. Review of Resident #22's February 2020 Physician order [REDACTED]. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, I expect for all nurses to sign off their controlled medication at the time the medication is administered. 4. The facility staff failed to ensure an accurate account of controlled medications for Resident #418. Resident #418 was admitted to the nursing facility on 02/17/20. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 11:55 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 1 with Licensed Practical Nurse (LPN) #2. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #418, [MEDICATION NAME] 300 mg count per record=4, actual count=3. On 03/02/20 at approximately 11:55 a.m., an interview was conducted with LPN #2 who stated, I did not give Resident #418 his morning [MEDICATION NAME], which was given by RN #1. She (LPN) said I retrieved the medication cart keys from RN #1 this morning but we never did a narcotic count; that was my mistake; we should have counted. An interview was conducted with RN #1 on 03/02/20 at approximately 1:15 p.m. The RN stated, I should have followed the 5 right for administering medication. He said I should have signed off on Resident #418's 9:00 a.m., [MEDICATION NAME] at the time it was administered. He said I should have counted with LPN #2 but it actually slipped my mind. Review of Resident #418's February 2020 Physician order [REDACTED]. On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. The facility policy titled Controlled Substances (Revised December 2012). -Policy statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Scheduled II and other controlled substances. Definitions: 1) [MEDICATION NAME] is used to relieve anxiety (www.nlm.nih.gov/medlineplus/drug). 2) [MEDICATION NAME] is used to treat anxiety disorders. 3) [MEDICATION NAME] is used alone or in combination with other medications to control certain types of [MEDICAL CONDITION]. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks) (https://medlineplus.gov). 4) [MEDICATION NAME] is used to help control certain types of [MEDICAL CONDITION] in people who have [MEDICAL CONDITION]. [MEDICATION NAME] capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles) (https://medlineplus.gov).

F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility documentation review the facility staff failed to ensure monthly medication reviews were readily available for review for 3 residents (Residents #21, #61, #71) and to ensure the physician reviewed pharmacy recommendations for 1 resident (Resident #112) of 57 residents in the survey sample. The findings included: On 03/05/2020 the following policy was reviewed regarding medication reviews: ORGANIZATIONAL ASPECTS IA2: CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS POLICIES AND PROCEDURES-Pharmacy Services for Nursing Facilities 2006 American Society of Consultant Pharmacists and MED-PAS, INC (Revised January 2018) (Pharmacy Name) RX August 2019 Policy-Regular and Reliable consultant pharmacist services are provided to residents. A written agreement with a consultant pharmacist stipulates financial arrangements, at fair market price, and the terms of the services provided. Review of the procedures revealed and is documented in part, as follows: F. Specific activities that the consultant pharmacist performs includes, but is not limited to: 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admission or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review (See IIIA1:MEDICATION REGIMEN REVIEW), and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues (at least monthly). 1. Resident #21 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #21's Minimum Date Set (MDS-an assessment protocol) with an Assessment Reference Date of 12/05/2019 coded Resident #21 with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #21 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019. The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 9:00 a.m., requested copies of Medication Regimen Reviews for April, May and June 2019. The facility was unable to provide Medication Regimen Reviews for April and June 2019. On 03/05/2020 at 2:30 p.m., during a briefing, the Director of Nursing was made aware of the finding. No further information was presented about the finding. 2. Resident #61 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #61's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 01/04/2020 coded Resident #61 with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #61 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019. The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 4:00 p.m., the facility reported they were unable to provide evidence of Medication Regimen Reviews for April, May and June 2019. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. No further information was presented about the finding. 3. Resident #71 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #71's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 01/09/2020 coded Resident #71 with short-term memory problems and long-term memory problems with severely impaired cognitive skills for daily decision making. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews for Resident #71 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019. The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 9:00 a.m., requested copies of Medication Regimen Reviews for April, May and June 2019. Medication Regimen review for April 2019 was received however they were unable to provide evidence of Medication Regimen Reviews for May and June 2019. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. No further information was presented about the finding. 4. Resident #112, the facility staff failed to ensure that the physician reviewed pharmacy recommendation. Resident #112 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #112's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 02/13/2020 coded Resident #112 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #112 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019. The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020 at approximately 12:00 p.m., Resident #112's Consultant Pharmacist Medication Regimen Review was reviewed and revealed and is documented in part, as follows: Recommendations: Please consider a dose reduction to [MEDICATION NAME] 5 mg (Milligram) at bedtime, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms. Date: [DATE]. On 03/04/2020 at approximately 12:15 p.m., review of Resident #112's Medication Administration Record [REDACTED]. Start Date: 09/24/2019 On 03/04/2020 at approximately 12:20 p.m., review of Resident #112's Medication Administration Record [REDACTED]. Start Date: 09/24/2019. An interview was conducted with Corporate Staff #3 on 03/05/2020 at 12:30 p.m Reviewed Consultant Pharmacist Medication Regiment Review with recommendations with Corporate #3. There was no evidence that the physician responded to the pharmacist recommendation. Reviewed Medication Administration records for months of February 2020 and March 2020 with Corporate #3. Corporate #3 stated, The process should be that the recommendation is posted to Polaris and then it goes to the DON (Director of Nursing) then the DON delegates to nursing or the Unit Manager then it is sent to the attending physician. The physician should document on the form, it should be documented and addressed on the pharmacist recommendation. Corporate #3 stated that he would check on it. On 03/05/2020 facility policy and procedure on Medication Regimen Reviews was received and included: ORGANIZATIONAL ASPECTS IA2: CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS POLICIES AND PROCEDURES-Pharmacy Services for Nursing Facilities 2006 American Society of Consultant Pharmacists and MED-PAS, INC (Revised January 2018) .Specific activities that the consultant pharmacist performs includes, but is not limited to: 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admission or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review ., and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues (at least monthly). G. The consultant pharmacist documents activities performed and services provided on behalf of the residents and the facility. 1) A written or electronic report of the findings and recommendations resulting from the activities as described above is given to the, attending physician, director of nursing, medical director and others as may be appropriate (e.g. administrator, regional manager, etc.) (at least monthly). The facility has a process to ensure that the findings are acted upon. On 03/05/2020 at 2:30 p.m., during a briefing the Director of Nursing was made aware of finding. The Director of Nursing stated, It should have been addressed within 7 days. As soon as we get the recommendation we should go ahead and get them out to the doctor. No further information was presented about the finding.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, medical record review, staff interviews and facility document review the facility staff failed to ensure 1 of 57 Residents in the survey sample, Resident #77, was free from unnecessary medications. The findings included: Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Under Section O Special Treatments, Procedures and Programs Influenza Vaccine A. Did the resident receive the influenza vaccine in the facility Resident #77 was coded as 1-Yes. On 3/3/20 at 12:20 P.M. a phone interview was conducted with Resident #77's daughter who was also the Resident's Responsible Party (RP) and Power of Attorney (POA). During the interview the POA stated, They gave her the flu shot after I told them I refused for her to have it. Resident #77's Informed Consent for Influenza Vaccine was reviewed and is documented in part, as follows: Under Informed Consent the following box was checked and Resident #77's POA's name was written in: I hereby DO NOT GIVE the facility permission to administer an influenza vaccination. Document was signed by LPN (Licensed Practical Nurse) #6. Resident #77's Electronic Medical Record was reviewed under the Immunization tab which indicated the following information: Update Immunization: Immunization: Influenza Given: Refused Reason Refused: POA Refused Consent Confirmed By: (Name) RN (Registered Nurse) #2 Consent Confirmed Date: 11/25/19 Resident #77's Physician order [REDACTED]. Resident #77's Medication Administration Record [REDACTED]. -Start Date-12/09/2019 Temp: 98.7 One Time: Nurse's Initials Time: 21:19 P.M. On 3/5/20 at 2:00 P.M. an interview was conducted with Registered Nurse (RN) #2 who is also the Staff Development Coordinator regarding Resident #77's Informed Consent for the Influenza Vaccine. RN #2 stated, I called the daughter on the phone and explained what the shot was for and the precautions and she said No, I don't want her to have the flu shot because she got it last year and no one asked me if she could have it. I said ok. Once I had the refusal I went into the computer and marked her as refusing under the immunization tab. The nurse that gives the shot should check for allergies and the consent in the computer before giving the medication. The nurse that gave her the flu shot doesn't work here anymore. On 3/5/20 at 2:40 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #6 regarding Resident #77's Influenza Vaccine. LPN #6 stated, Before I wrote the order I went into the immunizations tab but I didn't open it all the way so I didn't see the consent was refused. I tried to stop the order but the nurse already gave it. On 3/5/20 at 2:35 P.M. an interview was conducted with the Director of Nursing regarding what were her expectations of the staff with influenza vaccines. The Director of Nursing stated, I expect for them to follow the consent that is received. The Director of Nursing was also asked if it would be considered an unnecessary medication. The Director of Nursing stated, Absolutely, because it was by the daughter, we should not have given it. The facility policy titled Influenza Vaccine revised August 2016 was reviewed and is documented in part, as follows: 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. A facility Unnecessary Medication policy was not received from the facility prior to exit. On 3/5/20 at 3:50 P.M. a pre-exit

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	495150	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation review the facility staff failed to indicate the duration for an as needed [MEDICAL CONDITION] medication for 1 resident (Resident #100) and failed to perform a gradual dose reduction for 1 resident (Resident #20) of 57 residents in the survey sample. The findings included: Resident #100 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #100's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/04/2020 coded Resident #100 with short - term memory problems, long - term memory problems, and with severely impaired cognitive skills for daily decision making. On 03/04/2020 at approximately 10:00 a.m., review of Consultant Pharmacist recommendation revealed the following: The resident is on a PRN [MEDICAL CONDITION] drug: [MEDICATION NAME] Tablet 0.5 MG (Milligram) Give 1 tablet by mouth every 8 hours as needed for Anxiety PRN (As Needed) TID (Three Times A Day). Per federal regulations, PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days. For extension of PRN orders for [MEDICAL CONDITION] medications beyond 14 days or renewal of PRN therapy, the attending physician or prescribing practitioner must evaluate to determine appropriateness of therapy. Recommendations: Please consider either (1) discontinuing the PRN order, or (2) provide rational for extended time period and indicate a specific duration. Printed: 01/14/20. Review of recommendation did not evidence Physician response. On 03/04/2020 at approximately 11:00 a.m., review of Medication Administration Record [REDACTED]. On 03/04/2020 at approximately 11:10 a.m., review of Medication Administration Record [REDACTED]& [MEDICATION NAME] TAB 0.5MG PO TID. The resident has an HX (History) of Panic & anxiety disorder Resident PRN medication was d/c'd. His [MEDICATION NAME] was reordered and the patient improved. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. The Director of Nursing stated, I expect the nurses to call the doctor and ask him what he wants, ask him do you want to discontinue the order or schedule it? Director of Nursing stated, PRN order should be scheduled for 14 days. No further information was presented about the finding. The facility policy titled - Antipsychotic Medication Use Policy Statement: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Policy included the following: 14. The need to continue PRN orders for [MEDICAL CONDITION] medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 2. The facility staff failed to attempt a gradual dose reduction (GDR) for a [MEDICAL CONDITION] medication for Resident #20. Resident #20 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set ((MDS) dated [DATE] assessed this resident in the area of Cognitive Patterns for Brief Interview for Mental Status (BIMS) was a 15 indicating no cognitive impairment. A Consultant Pharmacist's Medication Regimen Review signed and dated 02/12/20 indicated: Recommendations: Routing MD - Note written to physician Resident is currently on [MEDICATION NAME] 10 Milligrams (mg) daily. Please consider a dose reduction to [MEDICATION NAME] 5 (mg) daily, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms. A review of a physician's orders [REDACTED]. A review of the Medication Administration Record [REDACTED]. A Consultant Pharmacist's Medication Regimen Review signed and dated 1/14/20 indicated: Resident is currently on [MEDICATION NAME] 50 mg daily. Recommendations: Please consider a dose reduction to [MEDICATION NAME] 25 mg daily, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms. A Physician order [REDACTED]. A review of the MAR for the month of March 2020 included: [MEDICATION NAME] 50 mg give one tablet orally at bedtime related to [MEDICAL CONDITION]. A revised care plan dated 0[DATE] indicated: Focus-Resident #20 uses antidepressant medications r/t Depression, and [MEDICAL CONDITION]. Goal-The resident will be free from discomfort or adverse reactions related to antidepressant therapy. Interventions-Administer Antidepressant medications as ordered by physician. Observe/document side effects and effectiveness Q (every) shift. Educate the resident about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Observe/document/report PRN adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea, gait change, rigid muscles, balance probes, movement problems, tremors, muscle cramps, falls; dizziness/[MEDICAL CONDITION]; fatigue, [MEDICAL CONDITION], appetite loss, wt loss, n/v dry mouth, and dry eyes. During an interview on 03/04/20 at 2:30 P.M. with the Cooperate Director of Nursing she stated, the physician was given notice of the pharmacist recommendation, but there is no indication that the GDR had been attempted.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on general observations of the nursing facility and staff interview, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles and stored according to manufacture guidelines in 3 out of 5 medication carts The findings included: 1. The facility staff failed to ensure one [MEDICATION NAME] (insulin) vial was dated once open for Resident #109. Resident #109 was originally admitted to the nursing facility on 04/20/15. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 11:37 a.m., the medication cart on Unit 4 was inspected with Licensed Practical Nurse (LPN) #1. During the inspection of the insulins stored inside the medication cart, one [MEDICATION NAME] vial was open with no open date. An interview was conducted with LPN #1 who stated, The [MEDICATION NAME] vial belongs to Resident #109 but does not have an open date; the insulin should have been dated once open. The [MEDICATION NAME] was removed from the medication cart by the nurse. Review of Resident #109's February 2020 Physician order [REDACTED]. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, All insulins must be labeled and dated once opened. 2. The facility staff failed to ensure medication label ([MEDICATION NAME]) was legible for Resident #75. Resident #75 was originally admitted to the nursing facility on 02/04/11. [DIAGNOSES REDACTED]. On 3/02/20 at approximately 11:37 a.m., the medication cart on Unit 4 was inspected with Licensed Practical Nurse (LPN) #1. During the inspection of the controlled medications stored inside the medication cart, a bottle of liquid [MEDICATION NAME] was observed but the resident's name was not legible (most of the name was missing). An interview was conducted with LPN #1 who stated, The medication belongs to (Resident #75). The LPN was asked, How do you know who the [MEDICATION NAME] belong to if most of the name on the bottle is missing she replied, I just know who the medication belong. The LPN stated, By looking at the [MEDICATION NAME] bottle, I am unable to identify who this medication belong too; I am unable to ready the label. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, If a label is not legible; the medication is not to be administered but a new label must be ordered from pharmacy first. The DON said Once the new label arrives, the nurse can administer the medication. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. The facility policy titled Labeling of Medication Containers (Revised 2007). Policy statement: All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. -Policy Interpretation and Implementation include but not limited to: Medication labels must be legible at all times. 3. The facility staff failed to ensure multi dose vials of liquid [MEDICATION NAME] was stored according to manufacture guidelines on 3 of 5 medication carts. During the inspection of the controlled medications stored inside the medication cart, liquid [MEDICATION NAME] bottles were observed. The label contain the following information: Store at cold

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) temperature - refrigerate between 36-46 degrees. The following Residents multi dose vials of liquid [MEDICATION NAME] (2 mg per ml) was observed on the medication carts: -Resident #75's (Unit 4). -Resident #83's (Unit 1). -Resident #43's (Unit 2). On 03/20/20 at approximately 11:37 a.m., an inventory of controlled medication was conducted on the medication cart located on Unit 4, assigned to Licensed Practical Nurse (LPN) #1. The LPN stated, The liquid [MEDICATION NAME] for Resident #75 should be stored in the medication refrigerator and not on the medication cart. On 03/20/20 at approximately 11:52 a.m., an inventory of controlled medication was conducted on the medication cart located on Unit 1, assigned to LPN #2. The LPN stated, The liquid [MEDICATION NAME] should be stored in the refrigerator. The LPN was asked, What is the purpose for storing liquid [MEDICATION NAME] in the refrigerator she replied, So the medication will not lose it potency. On 03/20/20 at approximately 12:30 p.m., an inventory of controlled medication was conducted on the medication cart located on Unit 2, assigned to LPN #3. The LPN stated, The liquid [MEDICATION NAME] for Resident #43 should be stored in the refrigerator after reviewing the label on the liquid [MEDICATION NAME]. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, Liquid (name of medication) should be stored in the refrigerator according to manufactures guidelines. -Manufacture Guidelines: How should I store [MEDICATION NAME]. Store [MEDICATION NAME] at a cold temperature. Refrigerate at 36 degrees to 46 degrees and protect from light. Definition: -[MEDICATION NAME] is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes) (https://medlineplus.gov/ency/article/ 5.htm). -[MEDICATION NAME] is used to relieve anxiety (www.nlm.nih.gov/medlineplus/drug).
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and review of facility documentation, the facility staff failed to prepare food by methods that conserves nutritive value and provide and present food that is palatable and attractive for 1 of 57 residents (Resident #89) in the survey sample. The findings include: Resident #89 was admitted to the nursing facility on [DATE] with [DIAGNOSES REDACTED]. The resident was readmitted on [DATE] with [DIAGNOSES REDACTED].*meniere's disease and urinary tract infection [MEDICAL CONDITION]. The most recent Minimum Data Set (MDS) assessment dated [DATE] was a significant change is status and coded the resident with moderate difficulty in hearing, usually has the ability to express ideas and wants and usually comprehends most conversation. Resident #89 was coded on this assessment as having short and long term memory and never/rarely made decisions. She was not coded to have mood or behavioral problems to have rejected care to include medications, treatments and or assistance with daily activities. The resident was coded to require limited assistance with one person for eating which indicated assistance to lift, hold or support trunk or arms less than half of the time. Resident #89 was coded to need assistance with personal care. This assessment indicated the resident had no significant weight loss or gain. Significant weight loss is a loss of 5% or more in the last month or a loss of 10% in the last 6 months. Significant weight gain is a gain of 5% or more in the last month or 10% or more in the last 6 months. The height of the resident was coded as 49 inches (4 feet and 1 inch) and weight 120 lb (pounds). The resident was coded to be on a mechanically altered therapeutic diet. The Care Area Assessment (CAA) dated [DATE] identified nutritional status as a care area that was triggered with a decision to care plan the area. The care plan dated [DATE] identified ADL (Activities of Daily Living) deficits and was at risk for dehydration. The goal the staff set for the resident was that she would be free of symptoms of dehydration and would receive the assistance she needed for ADL. One of the approaches to accomplish this goal included staff assistance to support the resident to eat and drink. The care plan dated [DATE] identified Resident #89 at risk for a nutritional problem and was on a low sodium, mechanical soft thin liquid diet. The goal the staff set for the resident was that she would tolerate the physician prescribed diet and have no significant weight loss through review date of [DATE]. The aforementioned care plan was not revised to reflect the physician prescribed diet order change dated [DATE] of NAS (no added salt) diet pureed texture, regular/thin consistency liquids. The rehabilitation screen dated [DATE] indicated the resident had a score of 9 out of a possible score of 15 which indicated Resident #96 was moderately impaired in the necessary cognitive skills for daily decision making. The screen noted that the nursing staff stated the resident suffered a decline in function following the death of her husband and was totally dependent for all ADLs. The resident had not been identified with weight loss at the time of this screen. The following observations were conducted of Resident #89 during meals: On [DATE] at 12:15 p.m., during tour of Unit 1, Resident #89 was observed in her room in a recliner. The lunch tray was sitting on the over bed table in front of the resident. Three pureed items (based on color) were noted on one plate. All three pureed items merged into each other that created one large multi-colored item. Individual sides included pureed bread and pureed cake. Un-opened ice cream, house shake and ice tea was also observed on the resident's tray. There was no soup on the resident's tray. When asked by this surveyor if she was hungry, she took her left hand and slightly lifted the side of the plate and said, I can't eat this slop. On [DATE] at 1:00 p.m. the lunch tray was removed. No portions or liquids had been consumed. The Certified Nursing Assistant (CNA) #5 said the resident required set up only and no help to eat and that she apparently was not hungry. CNA #5 recorded in the ADL record for the lunch meal on [DATE]-0,0 (independent with no help or staff oversight at any time and no setup or physical help from staff). The CNA recorded the resident consumed 0 % of her meal. On [DATE] at 5:15 p.m., the evening meal plate had three items on the one plate in the same configuration as the lunch meal. Side items included house shake, applesauce, the broth of the soup of the day, ice cream and ice tea. The resident was not assisted to eat any portions of the dinner meal. CNA #6 stated that the resident could independently eat her meal. The tray was picked up at approximately 6:00 p.m. CNA #6 recorded the resident's meal as 0,0. On [DATE] at approximately 12:20 p.m., the Resident Representative (RR) stated, The nurses leave the tray with no assistance. No alternatives offered because she does not like the meals, but will eat soup if they puree it. I was told by the current nutritionist in the kitchen that they do not puree soups. My Mom is losing too much weight now. The resident's tray had two main items on one plate merged into one with pureed bread, chocolate pudding, house shake and ice tea. The resident looked up at this surveyor, flicked the side of her plate and said, It looks like this everyday. They sit it in front of me day after day and walk off. The RR confirmed what the resident said. The RR stated when she asked how much weight the resident lost, they told her she was not losing weight, but she could tell based on how she looked in her clothes. The RR asked the resident if she would like thickened soup, to which the resident stated, I think I would accept that. On [DATE] at 1:00 p.m., one of the cooks of the kitchen was asked if soup could be pureed to which he responded that the Dietary Manager told him, No soups could be pureed. On [DATE], at approximately 1:22 p.m., the RR was at the bedside feeding the resident soup she brought in that was in a pureed consistency. The resident was observed to consume 75% of the soup and 100 % of ice tea. She stated the resident loved soup and would eat it if it was offered to her. She continued to say that she had a meeting with the nutritionist from the kitchen which was identified as the Dietary Manager and was told that he was unable to puree soup, but could strain the broth off the soup of the day and she felt that she had to accept his conditions. The RR stated, while crying, Her husband was also a resident here and they used to eat their meals together. He died two months ago. I am exhausted trying to keep my Mom going and I can only come every other day mostly. Things are different now she needs their help and without it she will keep losing more weight. She stated she was happy with everything and she did not expect miracles, but just help with her meals. The RR said she was told to consider Hospice, which she did, but stated she did not want the staff to write off Resident #89. Hospice services was implemented on [DATE] under [DIAGNOSES REDACTED]. The psychological counseling dated [DATE] to [DATE] continued to address the resident's grief from the loss of her husband. There was no physician's order for strained broth. The current physician's order dated was [DATE] of NAS (no added salt) diet pureed texture, regular/thin consistency liquids. On [DATE] at approximately 3:15 p.m., the Dietary Manager was asked what items could not be pureed to which he responded, Everything can be pureed, but lettuce. An interview was conducted with the Physician's Assistant (PA) on [DATE] at 11:45 a.m. She stated there was a speech consult based on the resident having swallowing difficulties after her last hospitalization on [DATE]. She stated she was out of the building in January and returned in the first week of February and did not know the resident was losing weight. The PA stated she expected if the resident was no longer eating, the staff would set up her tray accordingly and assist her to eat, offer alternatives and consult the RD. She stated she was with the attending physician's office and was playing catch up with seeing all of the facility residents, but possibly the attending was providing oversight for the resident's care when she was out. On [DATE] at 12:40 p.m., CNA #1 was observed feeding the resident strained broth. The CNA stated that the resident loved soup, but she had to go to the kitchen and get it for the current meal and consistently have to send for it, stating that it was supposed to be on every tray

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 12) because they knew she would eat it. She said she was not aware of any conversations that may have taken place about strained broth verses pureed soup, she just knew it was supposed to be on the tray every day for lunch and dinner. The CNA stated, As soon as she sees the pureed plate of food, she shakes her head. She won't touch it. The residents tell me they hate it. CNA #1 stated that she will sit and try and feed her all of the broth and hopefully she would eat the ice cream and mighty shake. The CNA stated for breakfast the resident had oatmeal and yogurt, but ate very little of it so she recorded 4,2 (total dependence-full staff assistance) with ,[DATE]% meal consumption. CNA #1 stated she offered Resident #89 in between snacks to include yogurt, pudding and ice cream, but there was no where in their charting system to record intake of the between meal snacks. On [DATE] at 10:15 a.m., and interview was conducted with the Rehabilitation Director (Rehab Director). The Rehab Director stated Resident #96 was screened [DATE] due to a cognitive decline and received speech therapy from [DATE] through [DATE] to facilitate safety and efficiency with visual aids to increase comprehension with receptive and expressive language training. There was a note that the resident was scheduled for an audiology appointment for hearing aids to decrease need for visual aids. The speech recommended and physician ordered diet dated [DATE] was for NAS (no added salt) diet mechanical soft texture, thin liquids consistency. The resident was screened again on [DATE] due to decrease in intake and significant weight loss ([DATE]=122.0; [DATE]=120; [DATE]=104). Her diet had been downgraded to a pureed texture during the [DATE] hospitalization . Resident #89 was assessed with [REDACTED]. During the above interview with the Rehab Director she called the Speech Therapist that serviced the resident to ask her if soup could be pureed. The Speech Therapist returned her call and stated Yes. This speech therapist wrote in one of her daily skilled service notes dated [DATE] that the resident requested soup and the speech therapist provided prepared pureed texture soup which was tolerated well with minimal throat clearing. The note further indicated, Speech Therapy instructed nurse manager regarding patient's risk of further weight loss and dehydration, and minimum to no intake with meals. The Rehab Director stated she did not understand why the resident was receiving broth/strained soup instead of pureed soup which was recommended in light of the resident's preference, her toleration of the textured soup and that there would be more nutritional value to assist resident and minimize weight loss. On [DATE] at 11:30 a.m., Resident #89's Speech Therapist joined the above interview and said that the resident was receiving the minimal of everything with strained soup/broth. The Dietary Manager joined the interview and stated although he did not have any notes or dates to refer to, he had a meeting with the family in February 2020 and told them that he would provide the resident with the broth of the soup of the day (cream of potato, cream of broccoli, noodle rice, Italian wedding, gumbo and tomato soup) and that the resident's family accepted his explanation. He stated, What do you expect me to do, pureed 4 ounces of soup. I would need to puree at least 20 ounces. If not done in bulk, it is difficult to puree. I don't have the equipment to puree small amounts and it would be a problem to reheat as well. The Registered Dietitian's (RD) progress notes dated [DATE] indicated a weight warning and that he recommended fortified foods at every meal related to poor intake and significant weight loss. The RD was on vacation and not available for interview. On [DATE] at 12:50 p.m., further interview was conducted with the Dietary Manager. He stated fortified foods included cereal, cream of wheat, oatmeal, house shake, frozen nutritional treats, mighty cups, yogurts and Jello pudding. He said although he did not have a date or had any notes of his discussion with the RD, he told her he was providing house shake, pudding, ice cream that would be equal to fortified foods. He stated he could not recall if he spoke to the RD about providing the resident broth of the soup of the day instead of the physician ordered pureed diet that could include pureed soup. On [DATE] at 1:50 p.m. Licensed Practical Nurse (LPN) on Unit 1 said that all of the residents that are served the pureed meals told her it looked nasty and had difficulty eating it based on looks and taste. She stated she sent the diet communication to the kitchen on [DATE] about adding a cup of broth with meals not based on a physician's order, but what the Dietary Manager said he was going to be sending the resident. On [DATE] at 2:30 p.m., the Director of Nursing (DON) stated although she was new in her position, she felt a different presentation of the meal could be more appealing to the residents on a pureed diet, either in individual small serving bowls or molds to represent the item served. She presented a list of 25 residents on pureed diet and stated that there would be no reason not the puree the soup of the day because there would be plenty of residents that could be offered pureed soups that could be prepared in bulk that would exceed 20 ounces. She stated she expected the resident to be provided as many fortified foods as possible at meal times and in between meals to foster an increase in calories. She said the resident required set up of all meals and that she expected the nursing staff to take the time to assist the resident to eat. Additionally, she said she did not know Resident #96 was receiving only broth and that she felt it was not offering enough calories to sustain the resident. On [DATE] at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit. The Dietary Manager's signed job description dated [DATE] indicated one of his many administrative functions was to process diet changes and new diets as received from nursing services, assist in developing methods for determining quality and quantity of food served, visit residents periodically to evaluate the quality of meals served, likes and dislikes, involve the resident, as well as the family in planning objectives and goals for the resident, follow directives from the Registered Dietician, review therapeutic and regular diet plans and menus to assure they are in compliance with the physician's orders and provide substitute foods similar in nutritive value to the residents who refuse foods served. The facility policy and procedure titled Nutrition (impaired)/Unplanned Weight loss-Clinical protocol dated ,[DATE] indicated the physician will authorize and the staff will implement appropriate general or cause-specific interventions to include resident choice, nutritional needs (dietician and physician to determine appropriate diet, supplemental needs), hydration needs and functional factors (providing feeding assistance as needed). The facility's policy and procedures titled Resident Nutrition Services dated ,[DATE] indicated that each resident is provided with a nourishing, palatable and attractive well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the preferences of each resident. Residents shall receive prompt meal service and appropriate feeding assistance. The facility policy and procedure titled Assistance with Meals dated ,[DATE] indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident. *People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely unable to swallow or may have trouble safely swallowing liquids, foods, or saliva(https://www.nidcd.nih.gov/health/dysphagia#1). *Meniere's disease is a disorder of the inner ear that can lead to dizzy spells ([MEDICAL CONDITION]) and hearing loss. In most cases, Meniere's disease affects only one ear (https://www.mayoclinic.org/diseases-conditions/meniere's-disease/symptoms-causes/syc- 910).
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews and facility document review the facility staff failed to store and prepare food in accordance with professional standards for food service safety. The findings included: On 3/2/20 at approximately 11:30 A.M. during the initial kitchen tour, the following observations were made: Dry Storage Room: 1-25 pound bag of parboiled rice not sealed, open to air with no date. 1-10 pound bag of macaroni noodles not sealed, open to air. 1 bag of bowtie pasta not sealed, open to air. Reach in Refrigerator #2: 1 gallon ziplock bag with a drink and a protein bar in it, which was immediately removed by the dietary aide that the food bag belonged to, stating it belonged to staff. 1 -2 pound package of smoked turkey breast sandwich meat not sealed, open to air. 1 open bag of boiled eggs with fluid leaking over other food contents in metal container. Main kitchen area: 1-50 pound bag of potato starch on back kitchen table not sealed, open to air, not dated and a large scoop sitting on top of the bag. 1-2 pound bag of light brown cane sugar not sealed and open to air that was sitting on a shelf below a return air vent. The return air vent was covered in a copious amount of dark gray sticky material. 1- 25 pound box of instant food thickener not sealed, open to air and a large scoop noted inside of the box lying on top of the food thickener. Drain flies were observed flying around the steam table, the trash can and the handwashing sink. Three drains were inspected in the dishwashing area. All three drains were noted to have copious amounts of thick black grease build up. One drain was noted to have 3 fruit flies inside of it. On 3/2/20 at 11:50 A.M. an interview was conducted with the Dietary Aide regarding fruit flies. The Dietary Aide stated, They are mainly in the dishwasher area. The Dietary Manager was informed of all the above findings. On 3/2/20 at approximately 12:15 P.M. the Dietary Manager was asked about his expectations for the storage of food and pests in the kitchen. The Dietary Manager stated, When something is opened it should sealed so it is not open to air or pests and dated. Also scoops are single use and should be washed after each use. The drains need to be cleaned. On 3/2/20 at approximately 12:25 P.M. the Director of

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	495150	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) Maintenance arrived in the kitchen and was shown the drains in the dishwasher area. The Director of Maintenance stated, I see the flies. The facility policy titled Food Receiving and Storage revised July 2014 was reviewed and is documented in part, as follows: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. 4. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in-first out system. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, review of facility documentation, and in the course of a complaint investigation, the facility failed to maintain complete and accurately documented medical records for 2 out of 57 resident records reviewed, Resident #53 and Resident #77. The findings included: 1. Resident #53 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #53's most recent MDS (Minimum Data Set) assessment was a Quarterly Review Assessment with an ARD (Assessment Review Date) of 12/30/2019. Resident #53's BIMS (Brief Interview for Mental Status) score was recorded as unobtainable. A review of the medical record for Resident #53 revealed a note documented on 12/24/2020 at 11:00 p.m., stating, Resident #53 remained in bed after returning from the ER. Further review of facility progress notes failed to provide dates and a description of events resulting in transfer to the emergency room (ER). On 3/5/2020 at approximately 12:10 p.m. the Corporate Director of Nursing responded to a documentation request with a SNF/NF to Hospital Transfer form dated 12/24/2019 detailing a hematoma to forehead. Surveyor asked the Corporate DON, Does this form accurately, thoroughly describe the events leading up to the hospitalization on or about 12/24/2020?, she responded, This transfer form describes why he was transferred to the hospital. He experienced a hematoma. Surveyor asked, Does this form describe how he received a hematoma? The Corporate DON responded, It details that he received a hematoma and that is why he was transferred to the hospital. These findings were reviewed with the Facility Administrator, DON and Corporate Staff during a briefing held on 3/5/2020 at approximately 5:00 p.m. There was no additional information provided. 2. Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Resident #77's Comprehensive Care Plan was reviewed and is documented in part, as follows: Focus: The resident has had episodes of Constipation related to [DIAGNOSES REDACTED]. Intervention: Record bowel movement pattern each day. Describe amount, color and consistency. During a complaint investigation Resident #77's Bowel Continence Documentation Flow Sheets for November 2019 were reviewed. Friday November 1st through the 4th for all three shifts were blank with no data entered. Resident #77's medical record and admission was reviewed and showed the resident was in the facility and receiving care from November 1-4, 2019. On 3/5/20 at 9:45 A.M. an interview was conducted with the Director of Nursing regarding the missing data for Resident #77 on the Bowel Continence Documentation Flow Sheets for Friday November 1st through the 4th for all three shifts. After reviewing the document the Director of Nursing stated, It's an incomplete record. I expect the staff to document and not leave any holes. The facility policy titled Charting and Documentation revised April 2008 was reviewed and is documented in part, as follows: Policy Statement: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical record. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided. Complaint deficiency.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, medical record review, staff interviews and facility document review the facility staff failed to follow the informed consent for the administration of the influenza vaccine for 1 of 57 Residents in the survey sample, Resident #77. The findings included: Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Under Section O Special Treatments, Procedures and Programs Influenza Vaccine A. Did the resident receive the influenza vaccine in the facility Resident #77 was coded as 1-Yes. On 3/3/20 at 12:20 P.M. a phone interview was conducted with Resident #77's daughter who was also the Resident's Responsible Party (RP) and Power of Attorney (POA). During the interview the POA stated, They gave her the flu shot after I told them I refused for her to have it. Resident #77's Informed Consent for Influenza Vaccine was reviewed and is documented in part, as follows: Under Informed Consent the following box was checked and Resident #77's POA's name was written in: I hereby DO NOT GIVE the facility permission to administer an influenza vaccination. Document was signed by LPN (Licensed Practical Nurse) #6. Resident #77's Electronic Medical Record was reviewed under the Immunization tab which indicated the following information: Update Immunization: Immunization: Influenza Given: Refused Reason Refused: POA Refused Consent Confirmed By: (Name) RN (Registered Nurse) #2 Consent Confirmed Date: 11/25/19 Resident #77's Physician order [REDACTED]. Resident #77's Medication Administration Record [REDACTED]. -Start Date- 12/09/2019 Temp: 98.7 One Time: Nurse's Initials Time: 21:19 P.M. On 3/5/20 at 2:00 P.M. an interview was conducted with Registered Nurse (RN) #2 who is also the Staff Development Coordinator regarding Resident #77's Informed Consent for the Influenza Vaccine. RN #2 stated, I called the daughter on the phone and explained what the shot was for and the precautions and she said No, I don't want her to have the flu shot because she got it last year and no one asked me if she could have it. I said ok. Once I had the refusal I went into the computer and marked her as refusing under the immunization tab. The nurse that gives the shot should check for allergies and the consent in the computer before giving the medication. The nurse that gave her the flu shot doesn't work here anymore. On 3/5/20 at 2:40 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #6 regarding Resident #77's Influenza Vaccine. LPN #6 stated, Before I wrote the order I went into the immunizations tab but I didn't open it all the way so I didn't see the consent was refused. I tried to stop the order but the nurse already gave it. On 3/5/20 at 2:35 P.M. an interview was conducted with the Director of Nursing regarding what were her expectations of the staff with influenza vaccines. The Director of Nursing stated, I expect for them to follow the consent that is received. The facility policy titled Influenza Vaccine revised August 2016 was reviewed and is documented in part, as follows: 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and facility document review the facility staff failed to maintain an effective pest control program. The findings included: 1. On 3/2/20 at approximately 1130 A.M. during the initial kitchen tour the following observations were made: Drain flies were observed flying around the steam table, the trash can and the handwashing sink. Three drains were inspected in the dishwashing area. All three drains were noted to have copious amounts of thick black grease build up. One drain was noted to have 3 fruit flies inside of it. On 3/2/20 at 11:50 A.M. an

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F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 14) interview was conducted with the Dietary Aide regarding fruit flies. The Dietary Aide stated, They are mainly in the dishwasher area. The Dietary Manager was informed of all the above findings. On 3/2/20 at approximately 12:15 P.M. the Dietary Manager was asked about his expectations for the storage of food and pests in the kitchen. The Dietary Manager stated, When something is opened it should sealed so it is not open to air or pests and dated .The drains need to be cleaned. On 3/2/20 at approximately 12:25 P.M. the Director of Maintenance arrived in the kitchen and was shown the drains in the dishwasher area. The Director of Maintenance stated, I see the flies. Throughout the survey gnats and fruit flies were also observed on Units 4 and 5. On 3/5/20 at 9:40 A.M. an interview was conducted with the Director of Maintenance regarding the pest observed in the facility. The Director of Maintenance provided documentation to show on 1/24/20 that 1 box of Terro Fruit Fly Traps had been ordered. The Director of Maintenance was asked if the traps had been effective. The Director of Maintenance stated, It has slowed them down. The facility policy titled Pest Control revised May 2008 was reviewed and is documented in part, as follows: Policy Statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided. 2. During an observation on 3/4/2020 at approximately 11:42 a.m., a live roach was seen swept by (Housekeeping) staff #12 on the Unit 1 hallway near room [ROOM NUMBER]. On 3/5/2020 at approximately 9:35 a.m., an inspection of the Unit 1 hallway was conducted along with the Facility Maintenance Director. Surveyor pointed out areas of missing baseboards on the walls of the hallway. The Facility Maintenance Director responded, We will fix that today. It's an issue in controlling pests. We are in the process of repairing those to help control pests getting into the facility. An interview held with Other (Housekeeping) staff #12 on 3/5/2020 at approximately 11:00 a.m. regarding sightings of roaches within the facility, Other #12 responded, I usually see roaches around two times per week and they are usually dead. A review of Facility Pest Sighting/Evidence Logs revealed: Unit 1: Sightings of live roaches in the dining room on 10/9/2019. Sightings of roaches in room [ROOM NUMBER] on 1/9/2020. Unit 2: Sightings of several roaches within the Social Services Office on 11/17/2019. Sightings of roaches in room [ROOM NUMBER]. Sightings in room [ROOM NUMBER] (unspecified type). Sightings of several roaches in the Social Services Office on 1/29/2020. Unit 4: Sightings of roaches on the main floors within rooms 115-123 on 1/28/2020. Sightings of roaches on main floors by room [ROOM NUMBER] on 2/5/2020. Unit 5: Sightings of roaches within rooms 83, 85 and the Dining Room on 12/2/2019. A review of Facility Vendor Customer Service Reports revealed, in part, the following: 1. A finding of floor tiles or baseboards loose/missing within resident rooms and kitchen area with a recommendation to repair to eliminate potential pest harborage/breeding site on 10/21/2019 and 11/21/2019. 2. A finding of spilled food material found on the floor, floor drains in need of cleaning and trash cans in need of cleaning, with a recommendation to clean to reduce pest attraction and source for breeding, on 1/24/2020. 3. A finding of hole/gap noted cracks and open areas around upper window frames and around air conditioner units allow for pest entry outside/inside, with a recommendation to seal to prevent pest entry or harborage on 2/20/2020. The Facility policy on Pest Control (rev. 5/2008) included: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 3. Windows are screened at all times. 4. Only approved FDA and EPA insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. 5. Garbage and trash are not permitted to accumulate and are removed from the facility daily. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services. These findings were reviewed with the Facility Administrator, DON and Corporate Staff during a briefing held on 3/5/2020 at approximately 5:00 p.m. There was no additional information provided.