STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSIDE HEALTH & REHAB CENTER	**4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interviews, and clinical record review, the facility staff failed to inform 3 residents (Resident #1, #5 and #6) out of 11 residents in the survey sample, of COVID-19 laboratory results for all COVID-19 test performed. The findings included: 1. Resident #1 was originally admitted to the facility 11/16/19, and has never been discharged . The resident's current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/1/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. On 9/2/20 at approximately 12:25 p.m., Resident #1 was observed standing in the hallway outside of (number of the room), without a mask, waving his hands above his head and yelling out to the staff near the nurse's station with the food service cart. A total of 4 staff were observed assisting with the food tray service and Resident #1 was unable to get their attention. Resident #1 proceeded to say, I want another COVID infection test, I had a test completed last week, about seven days ago and no one has said anything about the results. The resident further stated, I had two friends (stated the names of the friends), who lived in (number of the room), and they are gone. We were close and spent a lot of time together; I believe they have the infection but no one will tell me, I want another test. Resident #1 also stated I slept for 14 hours and I am still tired, I'm not hungry, and I was unable to do therapy. Yesterday I had a headache but not today. On 9/2/20, at approximately 12:44 p.m., an interviewed was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated no residents were present in (number of the room), when she accepted the assignment that morning and no one mentioned anything about the previous residents. Resident #1 was interviewed again on 9/2/20 at approximately 3:00 p.m. Resident #1 stated no one had responded to his request for another test, assessed him or even spoken with him about his concerns of weakness, sleeping for long periods, not being hungry or about headaches he had the day before. Review of facility records revealed Resident #1's close friends (Resident #10 and #11) in (number of the room) were no longer in the facility. An observation of Resident #10 and #11's room revealed storage of multiple items. Review of Resident #1's clinical record revealed laboratory results for a COVID-19 assay test which was completed 6/11/20. The result was dated 6/16/20 and it revealed the resident was negative for genetic markers of [MEDICAL CONDITION]. No other COVID-19 laboratory results were on his clinical record. A Social Services Note dated 6/16/2020 at 5:27 p.m., read Resident given update of COVID-19 status in the facility. Resident made aware of current resident who has tested positive for COVID-19. Family made aware of facility protocol pertaining to COVID-19. Resident encouraged to inquire anytime with questions, comments or concerns regarding facility status. No documentation in the clinical record read the resident was informed of his 6/16/20, COVID-19 test results. A telephone interview conducted with the Administrator and Director of Nursing on 9/7/20, at approximately 2:45 p.m., revealed Resident #1 was also tested for COVID-19 on 7/8/20, 8/27/20 and 9/4/20. Throughout the conversation about notifying the resident of his test results, others in the background repeatedly stated the results were negative. The facility's staff wouldn't share why they repeatedly stated the results were negative as we talked about informing Resident #1 of his results regardless if they were negative or positive especially since the resident was his own authorized representative and was expressing concerns about receiving the results. The clinical record revealed no laboratory results for the 7/8/20 testing. The Administrator stated during the 9/7/20, interview at approximately 2:45 p.m., that each resident didn't receive an independent laboratory results form therefore; a form wasn't available to put in the record and staff had not documented the results into each resident's individual record. The Administrator stated the 7/8/20, laboratory results were received in the facility 7/11/20. The following notes related to the 7/8/20, COVID-19 test was observed in Resident #1's clinical record; 7/11/2020 16:15 Family/Responsible Party Contact Note Text: Unable to reach family member (name of family member), regarding update of COVID-19 status in the facility and made aware facility protocol. 7/11/2020 18:12 Family/Responsible Party Contact Note Text: Unable to reach family member (name of family member), regarding update of COVID-19 status in the facility and made aware facility protocol pertaining to COVID-19 and taking necessary precautions. Resident has been made aware. Family encouraged to call anytime with questions, comments or concerns. No documentation in the clinical record read the resident was informed of his 7/8/20, COVID-19 test results. Information obtained from the Administrator during the 9/7/20 interview at approximately 2:45 p.m., also revealed Resident #1 had another COVID-19 test completed 8/27/20, and the results were received in the facility 9/2/20, per the Director of Nursing. As of 9/7/20, Resident #1's clinical record didn't contain the laboratory results for the 8/27/20, COVID-19 test and there was no documentation in his clinical record stating staff informed him of his COVID-19 test results which arrived to the facility 9/2/20. The clinical record revealed Resident #1 was seen by his primary physician 9/3/20, at approximately 2:35 p.m., for feeling tired and weak, sleeping 16 - 18 hours per day and expressing he believed he had the infection because his friends in another room had the COVID-19 infection. The physician's progress note dated 9/3/20 read; He has friends in other room, both of them got COVID-19 infection, seems like he is worried that he probably got it too. But he was checked last week, which was negative for infection. I reviewed his temperature log, it does not show he had fever. The physician's documentation didn't state the resident was informed of his 8/27/20, COVID-19 test results during her visit with him 9/3/20. An interview was conducted with the physician on 9/8/20 at approximately 3:30 p.m. The physician stated it's not her duty to inform each resident of their COVID-19 laboratory results but if she is seeing the resident she will talk to them about the results. The physician stated there wasn't documentation in her progress note that she informed the resident of his COVID-19 results but while she was seeing him she likely told him the results of his 8/27/20, COVID-19 test was negative. The following progress not was also observed in Resident #1's clinical record; 9/4/2020 19:06 Alert Note Text: Please note this writer and the Administrator met with the resident he was tested for COVID per the COVID Machine Sophia and negative. He was given his result. The Nurse Practitioner requested the test. The resident was without any signs/symptoms noted by this writer. He voiced he was afraid he had COVID because he watches the news and feels it's everywhere. On 9/9/20 at approximately 4:32 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated they had no policy for notification of residents and/or authorized representatives of laboratory results. 2. Resident #5 was tested on [DATE] for the COVID-19 virus. The nursing facility obtained the results of this test on 9/2/20. There was no evidence in the clinical record that the resident was notified of informed of his own test results which was negative for the COVID-19 virus. Resident #5 was admitted to the nursing facility on 8/7/19 with [DIAGNOSES REDACTED]. Resident #5's most recent Minimum Data Set (MDS) assessment was an Annual dated 8/8/20 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated he resident was

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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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) cognitively intact in the skills for daily decision making. On 9/2/20 at approximately 2:45 p.m., a phone interview was conducted with the Administrator, Director of Nursing (DON) and Corporate Nurse. Throughout the interview, they repeatedly stated there was no need to inform a resident if their COVID-19 test results were negative, and that a resident would be told if there was a positive result. Upon random review of Resident #5's progress notes from 8/27/20 through 9/9/20, both physician and nursing indicated the resident was engaged and that they elicited and shared information with him regarding care and services, but no evidence that he was informed of his COVID-19 status that resulted on 9/2/20. An interview was conducted with the physician on 9/8/20 at approximately 3:30 p.m. The physician stated it's not her duty to inform each resident of their COVID-19 laboratory results but if she is seeing the resident she may have possibly informed them about the results. The physician stated there wasn't documentation in her progress note dated 9/3/20 when she saw him for his routine long-term care assessment and evaluation that she informed the resident of the results of his 8/27/20, COVID-19 test which was negative. The clinical record recorded self which indicated he was capable of absorbing information about the care and services rendered to him by the nursing facility. During an interview with the Director of Nursing on 9/8/20 at 5:09 p.m., he stated he felt the person as primary would want to be concerned about medical issues and the authorized representative (AR) concerned about financial matters/decisions. There was no reason given why Resident #5 was not told of the outcome of his COVID-19 tests based on that information. On 9/9/20 at approximately 4:32 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated they had no policy for notification of residents and/or authorized representatives of laboratory results. 3. Resident #6 was tested on [DATE] for the COVID-19 virus. The nursing facility obtained the results of this test on 9/2/20. There was no evidence in the clinical record that the resident was notified of informed of his own test results which was negative for the COVID-19 virus. On 9/2/20 at approximately 2:45 p.m., a phone interview was conducted with the Administrator, Director of Nursing (DON) and Corporate Nurse. Throughout the interview, they repeatedly stated there was no need to inform a resident if their COVID-19 test results were negative, and that a resident would be told if there was a positive result. Upon random review of Resident #6's progress notes from 8/27/20 through 9/9/20, both physician and nursing indicated the resident was engaged and that they elicited and shared information with her regarding care and services, but no evidence that she was informed of her COVID-19 status that resulted on 9/2/20. An interview was conducted with the physician on 9/8/20 at approximately 3:30 p.m. The physician stated it's not her duty to inform each resident of their COVID-19 laboratory results but if she is seeing the resident she may have possibly informed them about the results. The physician stated there wasn't documentation in her progress note dated 9/3/20 when she saw him for his routine long-term care assessment and evaluation that she informed the resident of the results of his 8/27/20, COVID-19 test which was negative. Resident #6 was admitted to the nursing facility on 8/23/16 with [DIAGNOSES REDACTED]. The clinical record recorded the resident was the authorized representative (AR). During an interview with the DON on 9/8/20 at 5:09 p.m., he stated he felt the person listed as primary would want to be concerned about medical issues and the authorized representative (AR) concerned about financial matters/decisions. If was not clear if this was a reason why Resident #6 was not informed of her COVID-19 tests. Resident #6's most recent Minimum Data Set (MDS) assessment was an Annual dated 8/3/20 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was cognitively intact in the skills for daily decision making. On 9/9/20 at approximately 4:32 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated they had no policy for notification of residents and/or authorized representatives of laboratory results.
F 0775 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep complete, dated laboratory records in the resident's record.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interviews, and clinical record review, the facility staff failed to file in the resident's clinical record all COVID-19 laboratory results for one resident (Resident #1), out of 11 residents in the survey sample. The findings included: Resident #1 was originally admitted to the facility 11/16/19, and has never been discharged . The resident's current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/1/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. On 9/2/20 at approximately 12:25 p.m., Resident #1 was observed standing in the hallway outside of (number of the room), without a mask, waving his hands above his head and yelling out to the staff near the nurse's station with the food service cart. Resident #1 proceeded to say I want another COVID infection test, I had a test completed last week, about seven days ago and no one has said anything about the results. Review of Resident #1's clinical record revealed laboratory results for a COVID-19 assay test which was completed 6/11/20. The result was dated 6/16/20 and it revealed the resident was negative for genetic markers of [MEDICAL CONDITION]. No other COVID-19 laboratory results were on his clinical record. An interview with the Administrator and Director of Nursing on 9/7/20, at approximately 2:45 p.m., revealed Resident #1 was also tested for COVID-19 on 7/8/20, 8/27/20 and 9/4/20. The clinical record revealed no laboratory results for the 7/8/20 testing which was conducted by the National Guard. The Administrator stated during the 9/7/20, interview at approximately 2:45 p.m., that each resident didn't receive an independent laboratory result form therefore; a form wasn't available to put in the record and staff had not documented the results into each resident's individual record. The Administrator stated the 7/8/20, laboratory results were received in the facility 7/11/20. Information obtained from the Administrator during the 9/7/20 interview at approximately 2:45 p.m., also revealed Resident #1 had another COVID-19 test completed 8/27/20 (by an independent laboratory), and the results were received in the facility 9/2/20, per the Director of Nursing. As of 9/7/20, Resident #1's clinical record didn't contain the laboratory results for the 8/27/20, COVID-19 test and there was no documentation in his clinical record stating staff informed Resident #1 of his COVID-19 test results. On 9/9/20 at approximately 4:32 p.m., the above findings were shared with the Administrator and the Director of Nursing. They stated they had no policies/procedures for when laboratory results should reach the clinical record or when the individual and/or responsible party should receive their laboratory results.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 inform residents, their representatives and or families of those residing in the facility, by 5 p.m. the next calendar day of confirmed infection of COVID-19 for 9 of 11 residents (#5, #6, #7, #8, #9, #1, #2, #3 and #4) in the survey sample. Forty-eight facility residents were tested for the COVID-19 virus on 8/27/20. Ten out of the 48 residents results were positive for [MEDICAL CONDITION] on 9/2/20 (Wednesday), however there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed COVID-19 updates. The findings included: 1. Resident #5 was one of the sampled residents from the list. Although this resident tested negative for [MEDICAL CONDITION], there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed updates to inform Resident #5 that there were one or more confirmed cases of COVID-19 in the nursing facility. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent Minimum Data Set (MDS) assessment was an Annual dated 8/8/20 and coded the resident with a score of 15 out of a possible score of 15 on Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills needed for daily decision making. 2. Resident #6 was one of the sampled residents from the list. Although this resident tested negative for [MEDICAL CONDITION], there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed updates to inform Resident #6 that there were one or more confirmed cases of COVID-19 in the nursing facility. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent Minimum Data Set (MDS) assessment was an Annual dated 8/3/20 and coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills needed for daily decision making. 3. Resident #7 was one of the sampled residents from the list. Although this resident tested negative for [MEDICAL CONDITION], there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed updates to inform Resident #7 that there were one or more confirmed cases of COVID-19 in the nursing facility. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent Minimum Data Set (MDS) assessment was an admitted d 8/25/20 and coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills needed for daily decision making. 4. Resident #8 was one of the sampled residents from the list. Although this resident tested negative for [MEDICAL CONDITION], there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed updates to inform Resident #8 that there were one or more confirmed cases of COVID-19 in the nursing facility. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The

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F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) resident's most recent Minimum Data Set (MDS) assessment was a Quarterly dated 7/31/20 and coded the resident with a score of 00 out of a possible score of 15 which indicated the resident was not cognitively intact in the skills needed for daily decision making. 5. Resident #9 was one of the sampled residents from the list. Although this resident tested negative for [MEDICAL CONDITION], there was no evidence on or before 9/3/20 by 5 p.m., in any format or discipline, that relayed updates to inform Resident #9 that there were one or more confirmed cases of COVID-19 in the nursing facility. Resident #9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent Minimum Data Set (MDS) assessment was a Quarterly dated 7/8/20 and coded the resident with a score of 00 out of a possible score of 7 which indicated the resident was not cognitively intact in the skills needed for daily decision making. During a phone interview with the Administrator on 9/8/20 at 5:09 p.m., he stated the method used to inform and update residents, guardians and families of one or more cases of COVID-19, residents and or staff in the facility was through direct Robo calls. The Administrator said there was a template used in the Robo calls that is documented in each resident clinical record. The Administrator stated there was no policy or procedure to support the mandate, but they used the federal regulatory guidance. There was no evidence that the residents or families were notified via the method described by the Administrator. 6. Resident #1 was originally admitted to the facility 11/16/19, and has never been discharged . The resident's current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/1/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. Review of facility's documentation revealed Resident #1 tested negative but ten other residents tested positive for COVID-19 on 8/27/20 and the results were made available to the facility 9/2/20. Review of the resident's clinical record revealed the resident was his own authorized representative, yet there was no documentation in the resident's clinical record revealing the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., on 9/3/20. 7. Resident #2 was originally admitted to the facility 12/16/19, and was discharged to an acute care hospital returning to the facility 4/29/20. The resident's current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/19/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. Review of facility's documentation revealed Resident #2 tested negative but ten other residents tested positive for COVID-19 on 8/27/20 and the results were made available to the facility 9/2/20. Review of the resident's clinical record revealed the resident was his own authorized representative, yet there was no documentation in the resident's clinical record revealing the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., on 9/3/20. 8. Resident #3 was originally admitted to the facility 4/24/14, and has never been discharged . The resident's current [DIAGNOSES REDACTED]. This indicated Resident #3's cognitive abilities for daily decision making were intact. Review of facility's documentation revealed Resident #3 tested negative but ten other residents tested positive for COVID-19 on 8/27/20 and the results were made available to the facility 9/2/20. Review of the resident's clinical record revealed the resident was his own authorized representative, yet there was no documentation in the resident's clinical record revealing the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., on 9/3/20. 9. Resident #4 was originally admitted to the facility 2/26/15, and was discharged to an acute care hospital returning to the facility 4/29/19. The resident's current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/25/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were intact. Review of facility's documentation revealed Resident #4 tested negative but ten other residents tested positive for COVID-19 on 8/27/20 and the results were made available to the facility 9/2/20. Review of the resident's clinical record revealed the resident was his own authorized representative, yet there was no documentation in the resident's clinical record revealing the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., on 9/3/20. On 9/9/20 at approximately 4:32 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Administrator stated the facility utilizes a ROBO texting system and all resident and/or the authorized representative are notified of new cases of COVID-19 diagnosed in the facility within the required time span. There was no evidence that the residents and/or authorized representatives were notified by the described method. The facility's undated policy titled Resident/Family/Responsible Party COVID-19 Notification Requirements read under Subsequent Probable of Positive Case: Call each responsible party and inform them of the facility's COVID status within 12 hours. Under Weekly Updates following the first probable or Positive case or three residents or staff with Respiratory symptoms within 72 hours: Call each responsible party and inform them of the facility's COVID status until no more positive or probable cases are present in the facility.