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Commonwealth Senior Living at the Ballentine
7211 Granby Street
Norfolk, VA 23505
(757) 440-7400

Current Inspector: Donesia Peoples (757) 353-0430

Inspection Date: Feb. 10, 2021 and Feb. 11, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1
Subjectivity

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A renewal inspection was initiated on 02-10-2021 and concluded on 02-11-2021. The Administrator was contacted by telephone to initiate the inspection. The Administrator reported that the current census was 50. The inspector emailed the Administrator a list of items required to complete the inspection. The inspector reviewed 3 resident records, 3 staff records, criminal background checks and sworn disclosures of newly hired staff, staff schedules, fire drills, fire and health inspection reports, dietary oversight, and healthcare oversight.

Information gathered during the inspection determined non-compliances with applicable standards or law, and violations were documented on the violation notice issued to the facility.

Violations:

Standard #:	22VAC40-73-450-C
Description:	Based on resident record review and interview, the facility failed to ensure the Individualized Service Plan (ISP) included a description of identified needs. Evidence: 1. Resident #1?s signed physician?s orders dated 01-07-2021 documented, continuous Oxygen via Nasal Cannula 2LPM; and allergies to Penicillins, Nitrofurantoin, Shellfish, and Sulfamethoxazole/Trimetheoprim. 2. Resident #1?s current ISP dated 02-04-2021 did not document the need for continuous oxygen or the liter flow rate, nor aforementioned allergies. 3. Resident #2?s current Uniform Assessment Instrument dated 09-14-2020 documented the need for mechanical and physical assistance with toileting and dressing; mechanical assistance with stairclimbing; and bladder incontinence weekly or more. 4. Resident #2?s current ISP dated 09-14-2020 did not document the type of mechanical device needed for assistance with toileting, dressing, and stairclimbing; or bladder incontinence. 5. Staff #1 and staff #2 acknowledged resident #1 and resident #2?s aforementioned needs were not identified on the ISP?s.
Plan of Correction:	The Resident Care Director or designee will ensure that each ISP is reviewed and updated annually or if there is a change in the resident condition to include the assessed needs as per the UAI. Resident # 1 and #2 ISP was updated to reflect assessed needs. The ISPs of other residents were reviewed to ensure compliance. Records reviewed to include identified need, oxygen orders, allergies and mechanical assistance needed. Community will continue to complete Preliminary ISP and Comprehensive ISP in conjunction with resident, family, and/or caregivers while using the History and Physical, physician orders, UAI, and other support to ensure the individualized basic needs of the resident are adequately identified to include type of assistance needed to protect the resident?s health, safety, type of assistance required by coordinated

	to include type of assistance needed to protect the resident?s health, safety, type of assistance required by coordinated services if applicable, and required signatures. Executive Director will review the Preliminary ISP on the date of admission. Executive Director, Resident Care Director, and/or designee reviewed other ISPs to ensure compliance. Executive Director will complete random monthly audit of a minimum of 4 Comprehensive ISPs to ensure ongoing compliance.
Standard #:	22VAC40-73-480-C
Description:	Based on record review and interview, the facility failed to arrange for specialized rehabilitative services by a qualified personnel as needed by the resident, to include physical and occupational therapy services. Evidence: 1. The ?Progress Notes? [nursing notes] documented resident #2 fell on 01-09-2021. 2. Resident #2?s signed physician?s orders dated 01-13-2021 documented, ?PT/OT [physical and occupational therapy] eval and treat- falls.? 3. Staff #1 could not provide documentation verifying resident #2 was evaluated and treated by PT/OT as of 02-13-2021. Additionally, no documentation was provided indicating the therapists was contacted regarding the aforementioned order as of 02-13-2021. 4. Staff #1 acknowledged the facility did not arrange for PT/OT services as ordered by the physician on 01-13-2021.
Plan of Correction:	Resident has been evaluated for therapy services. All physician orders for specialized rehabilitative services were reviewed. Process to refer, evaluate, and treated reviewed and re-educated with therapy partner. Resident Care Director or designee will review all physician orders daily. Resident Care Director or designee will ensure that therapeutic services, evaluation and treatment begin timely. Executive Director, Resident Care Director, or designee to complete random monthly audit of physician orders for therapy and evaluation to ensure ongoing compliance.
Standard #:	22VAC40-73-650-C
Description:	Based on record review and interview, the facility failed to ensure the physician's oral orders are reviewed and signed by a physician within 14 days. Evidence: 1. Resident #1?s ?Physician?s telephone/verbal order? dated 01-10-2021 documented, ?May hold Ambien until supply arrives.? The order was not reviewed and signed by a physician as of 02-11-2021. 2. Staff #1 and staff #2 acknowledged resident #1?s verbal order was not reviewed and signed by a physician within 14 days.
Plan of Correction:	A signed order was obtained from the prescriber during the monitoring visit. Resident Care Director and Assistant Resident Care Director reviewed all prescriber?s oral orders to ensure that they are signed by a physician or other prescriber as required by BON and Licensing Standards. Resident Care Director, Assistant Resident Care Director, or designee will review all oral orders daily to ensure continued compliance.
Standard #:	22VAC40-73-680-E
Description:	Based on record review and interview, the facility failed to ensure treatments ordered by a physician or other prescriber are provided according to his instructions and documented. The documentation should be maintained in the resident's record. Evidence: 1. Resident #1?s signed physician?s orders dated 01-07-2021 (original order dated 08-05-2020) documented, ?Oxygen-Continuous, Continuous Oxygen via Nasal Cannula 2LPM.? 2. Continuous oxygen was not documented on resident #1?s January and February 2021 Medication Administration Record (MAR) or Treatment Administration Record (TAR). Staff #1 and staff #2 could not provide documentation verifying resident #1 received continuous oxygen daily on 01-01-2021 through 01-31-2021, and 02-01-2021 through 02-08-2021; nor could staff provide a discontinued order for the oxygen. 3. Resident #2?s signed physician?s orders dated 01-07-2021 documented ?Vital signs- one time per day 5th at 9:30 PM. Vitals: Blood Pressure, Breathing Rate, Pulse, Temperature.? 4. Resident #2?s February 2021 MAR documented the following vital signs: A. Blood Pressure taken on 02-01-2021 through 02-07-2021 during the 9:30 AM and 5:00 PM administration time; and on 02-08-2021 during the 5:00 PM administration time. B. Pulse taken on 02-03-2021 and 02-04-2021 during the 5:00 PM administration time. C. Breathing rate and temperature taken on 02-05-2021 during the 9:30 PM administration time. 5. Staff #1 and staff #2 acknowledged resident #1?s oxygen was not provided in accordance with the physician?s instructions and was not documented in the resident?s record, and resident #2?s vital signs were not provided in accordance with the physician?s instructions.
Plan of Correction:	All oxygen orders were reviewed and revised as necessary to correlate with current physician orders. Resident Care Director to re-educate Nurse and RMAs on the 5 rights of medication administration to include re-ordering, administration, and discontinuing of medications in accordance with the physician?s order and Board of Nursing standards. Resident Care Director or designee will approve all new medication orders in the EMAR system as well as discontinuation orders. Executive Director, Resident Care Director, or designee to complete random monthly audit of physician orders to ensure ongoing compliance.