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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Norfolk	1005 Hampton Blvd Norfolk, VA 23507

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility documentation, the facility staff failed to immediately inform the physician of the need to assess/evaluate, start, or alter treatment when there was a significant deterioration in the resident's condition for 1 of 59 residents (Resident #46) in the survey sample. The findings included: Resident #46 had four (4) falls between 04/24/23 - 05/22/23 and during that time she had behavioral and neurological changes. She was at risk for major injury related to being on an anticoagulation medication (blood thinner), independent with ambulation, and a diagnosis of dementia. The resident was not assessed after significant behavioral and neurological changes were identified. The resident was transferred to the local emergency room (ER), and diagnosed with subdural hematoma/hemorrhage. Resident #46 was transferred via 911 (emergent) to the local hospital on [DATE] due to acute left-sided weakness and altered mental status following a ground-level fall at the nursing facility. A computerized tomography (CT) scan was done to reveal a subdural hematoma/hemorrhage. On 05/23/23, Resident #46 underwent right [NAME] hole subdural hematoma evacuation with subdural drain placement. Resident #46 was originally admitted to the nursing facility on 05/14/21. Diagnosis for Resident #46 included but was not limited to acute subdural hemorrhage, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of pulmonary embolism (a blood clot in the lungs), and cerebral infarction (stroke). The Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 04/28/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence on one with bathing, limited assistance of one with personal hygiene, supervised with limited assistance of one with dressing and toilet use, supervisor with one assistance with eating and transfer, and independent with bed mobility, locomotion on/off the unit, walking in room and corridor with a steady gait all the time. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Minimum Data Set (MDS - an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 06/12/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, personal hygiene, and toilet use, and supervision with one assistance with eating for Activities of Daily Living (ADL) care. Under section G0300 (Balance during transitions and walking) was coded gait not steady, only able to stabilize with human assistance. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident at risk for falls related to psychotropic medication use. The goal set for the resident by the staff was that the resident will remain free from injury. Some of the interventions/approaches the staff would use to accomplish this goal are to assist with all transfers and mobility, obtain physical therapy (PT) consult as needed, resident is self-ambulatory and attempt to toilet resident every 2-3 hours and as needed. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident receiving anticoagulant therapy (blood thinner) due to a history of Pulmonary Embolism (PE). The goal set for the resident by the staff was that the resident will have no active bleeding. Some of the interventions/approaches the staff would use to accomplish this goal are to observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae (tiny purple spots under the skin), purpura (rash of purple spots under the skin), ecchymosis (bruising) areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, and epistaxis). A review of Resident #46's Medication Administration Record (MAR) for May 2023 revealed an order to administer Xarelto (blood thinner) 20 mg by mouth daily with dinner (for a history of pulmonary embolism). A nurse's note entered by License Practical Nurse (LPN) #2 on 04/24/23 at 10:47 a.m., documented Resident #46 with swelling and bruising to the left side of the face near the cheek bone. When asked what happened, Resident #46 said she almost fell getting the baby and pointed at the nightstand. The resident denied falling but has a diagnosis of dementia. The nightstand was re-arranged further away from the bed. The physician and Resident Representative (RR) were made aware of the above incident. According to the nurses' note dated 04/25/23 at 3:30 a.m., Resident #46 continued with swelling at the left upper cheek area and now to the outer corner of the left eye. On the same day at 2:49 p.m., Resident #46 was observed with a red spot on the sclera (the white outer layer of the eyeball), and swelling and bruising remained on the left side of the face. Further review of the note did not indicate the physician or Nurse Practitioner (NP) was informed related to the red spot observed on the sclera. On 04/28/23 at 8:22 a.m., a nurses' note entered by LPN #8 documented Resident #46 with increased pain in the left eye. The resident was medicated with Motrin (pain medication) with effective results. Further review of the note did not indicate the physician or NP was informed. A review of Resident #46's nurse's notes revealed on 05/10/23 at 1:45 p.m., the resident was observed with increased agitation. She refused her afternoon medications and vital signs. The note also indicated Resident #46's flooded the bathroom in (room #) with tissue paper and storage equipment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/11/23, according to Resident #46's nurses' note, Resident #46 refused her afternoon medications and vital signs. On the same day, observed with increased agitation. The resident was seen by the Psych Nurse Practitioner (NP). The psych NP note documented resident was being seen today for a follow-up evaluation for a medication check. Resident #46 refusing medication, patient care and not eating. Resident #46 noted with increase paranoia which is something new. New orders were given for Urine Analysis (UA) with Culture and Sensitivity (C&S), Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) in the morning. The psych NP was interviewed on 07/21/23 at 2:51 p.m. He stated he was asked by nursing to see Resident #46 on 05/11/23 for increased agitation/behaviors. He stated he ordered labs on Resident #46 but it was the responsibility of the resident's primary physician to follow up with any necessary treatment. On 05/12/23, a change in condition form was completed on Resident #46. The form identified Resident #46 with increased confusion or disorientation and new or worsened delusions or hallucination. Resident #46 observed requiring more assistance with ADL's. The physician was informed of change in condition. Further review of the clinical record did not reveal a MD or NP visit related to change in condition with Resident #46. A nurses' note entered on 05/14/23 at 8:06 a.m., documented Resident #46 had a fall on the (11-7 shift). At this time, the resident was observed with a limp while dragging her left leg during ambulation. A message was left for the physician but did not indicate the physician returned the call. On 05/14/23 at 10:17 p.m., it was documented in the nurses' notes Resident #46 noted with increased agitation to noise, tremors, and unsteady gait and required two persons assist with care. Further review of the clinical record did not indicate the physician or NP was notified. A review of Resident #46's nurses' note dated 05/15/23 at 6:15 p.m., indicated the resident had been found on the floor in her bathroom without pain or discomfort. The note indicated neuro checks were within normal limits (WNL). A nurses' note dated 05/17/23 at 12:58 p.m., documented day three (3) after an unwitnessed fall indicated Resident #46 required max assist of two (2) person assistance with walking. The note documented the resident had been evaluated by therapy and Resident #46 was unaware of her left lower extremity when moving from sit/stand during therapy sessions. On 07/21/23 at 9:51 a.m., an interview was conducted with the Physical Therapist (PT). He stated Resident #46 was evaluated and picked up by therapy due to requent falls with poor safety awareness. He stated Resident #46 was dragging her left leg; unable to pick that leg up. He stated prior to her falls, Resident #46 was independent with ambulation and did not require an assistance device (walker or wheelchair). Resident #46 was evaluated by PT on 05/17/23. According to the evaluation, Resident #46 was seen for a significant decline in her functional mobility skills and what appears to be left lower extremity hemiplegia (weakness or partial paralysis on one side of the body.) It was documented the resident was unable to ambulate and required max assistance with transfers. It was also documented Resident #46 required the use of a wheelchair and Pommel seat cushion to reduce her risk of falls. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/21/23 at 4:14 p.m., an interview was conducted with the Director of Nursing (DON) with five (5) other surveyors present. She stated on 05/14/23, when Resident #46 exhibited increased sleeping, reaching for objects, and observed with tremors, the physician should have been notified. She stated the resident could be having neurological issues. She stated Resident #46 needed further evaluation and a clinical assessment by the physician or NP, but it didn't happen. The DON stated according to the nurses on 05/16/23, Resident #46 is leaning towards the left side and required assistance with ambulation which is abnormal for her. She stated when the NP was informed on 05/17/23 that Resident #46 noted with an increase in leaning to her left side with weakness, Resident #46 needed to be evaluated. The DON stated according to the resident's clinical record, the physician or NP did not assess Resident #46 from 05/12/23 when she first showed a change in condition to include frequent falls until she was discharged to the hospital on [DATE] with a subdural hemorrhage. The DON was asked if the physician or NP should have come to evaluate/assess Resident #46 she replied, Absolutely. She stated the facility/provider did not do further assessments to determine what the root cause of the change in condition was for Resident #46's. Resident #46 had an unwitnessed fall in the day room on 05/22/23. She was sent to the local emergency room (ER) via 911 emergence for further evaluation. On the same day at 9:50 p.m., the facility received a call from (name of hospital) informing them that Resident #46 was admitted to the Neuro Intensive Care Unit (ICU). A review of the hospital record revealed Resident #46 presented in the emergency room (ER) on 05/22/23 from (name of nursing facility) for further evaluation due to acute left-sided weakness and altered mental status following a ground-level fall at the nursing facility. The note indicated a subdural hemorrhage/hematoma may have been the result due to the ground-level fall. Over the past several days, Resident #46 had worsening gait instability and falls, and today observed with weakness in her left arm. The note indicated a computerized tomography (CT) scan was done to reveal a subdural hematoma/hemorrhage. On 05/23/23, Resident #46 underwent right [NAME] hole subdural hematoma evacuation with subdural drain placement. The resident remained in the Neuro Intensive Care Unit (ICU) for close monitoring and subdural drain until 05/25/23. A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Clinical Operations on 07/21/23 at approximately 5:30 p.m. No further information was provided prior to exit. Definitions -Xarelto is used to treat deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in adults. Rivaroxaban is also used to prevent DVT and PE from happening again after initial treatment is completed in adults (https://medlineplus.gov/druginfo/meds). Subdural hemorrhage -A subdural hematoma is a type of bleed inside your head. It's a type of bleed that occurs within your skull but outside the actual brain tissue. Other names for subdural hematoma are subdural hemorrhage or intracranial hematoma. More broadly, it is also a type of traumatic brain injury (TBI). How do subdural hematomas happen? (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Head injuries cause most subdural hematomas. If you fall and hit your head or take a blow to the head in a car or bike accident, a sporting activity or have another type of head trauma, you are at risk for developing a subdural hematoma. Are some people more likely to get a subdural hematoma? -People who take blood thinners: Blood thinners slow down the clotting process or prevent blood from clotting at all. If blood doesn't clot, bleeding can be severe and long-lasting, even after a relatively minor injury. Being careful when taking blood thinners: Even minor head injuries can cause a subdural hematoma in people who take blood thinners. What are the symptoms of subdural hematoma? -Because a subdural hematoma is a type of traumatic brain injury (TBI), they share many symptoms. Symptoms of a subdural hematoma may appear immediately following trauma to the head, or they may develop over time - even weeks to months. Signs and symptoms of a subdural hematoma include but are not limited to: -Confusion and drowsiness. -Slurred speech and changes in vision. -Dizziness, loss of balance, difficulty walking. -Weakness on one side of the body. -Memory loss, disorientation, and personality changes, especially in older adults with chronic subdural hematoma. Special note about head injury and symptoms in seniors: -Some of the symptoms of subdural hematoma in older people, like memory loss, confusion, and personality changes, could be mistaken for dementia. The older person may not remember hitting their head. Sometimes, people forget because they are disoriented. Other times, the injury was minor and may have occurred weeks before symptoms appeared. They should still see their healthcare provider for evaluation. What are the treatments for subdural hematoma? -Healthcare providers treat larger hematomas with decompression surgery. A surgeon drills one or more holes in the skull to drain the blood. Draining the blood relieves the pressure the blood buildup causes on the brain (https://my.clevelandclinic.org/health/diseases/21183-subdural-hematoma).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, resident interviews and staff interview, the facility staff failed to ensure the sink in Resident #120's room drained after use for 1 of 59 residents (Resident #120), in the survey sample. The findings included: Resident #120 was originally admitted to the facility 3/8/23 after an acute care hospital stay. The resident had never been discharged from the facility. The current diagnoses included; high blood pressure, high cholesterol and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #120's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring physical help of one person with bathing, limited assistance of one person with dressing, supervision of one person with transfers, locomotion, toileting, and personal hygiene, independent after set-up with eating and walking, and independent with bed mobility. On 7/18/23 at approximately 4:35 p.m., during the initial tour the sink in Resident #120's bathroom was observed to be 1/3 full of standing water. An interview was conducted with Resident #120 on 7/18/23 at approximately 4:37 p.m. The resident stated there had been problems with the sink draining completely for many months. The resident also stated the toilet flushes but it is a matter of knowing the trick to hold the handled down until all of the waste is gone out of the commode. He further stated the roommate does not understand how to manage the toilet even though he had explained it to him multiple times. On 7/19/23 at approximately 1:40 p.m., another observation was made of Resident #120's bathroom sink. This time it was 2/3 full with soapy water. Resident #120 stated the roommate left the water running and when he went in, it was almost full. On 7/20/23 at approximately 11:45 p.m., the sink was again observed in Resident #120's room. It was still approximately 2/3 full with standing water, the pipes under the sink had been taken apart and a bucket had been placed beneath the sink to capture water. An interview was conducted with Resident #120 at approximately 11:46 p.m. The resident stated Maintenance was working on the sink but there was no improvement thus, he had given up on the sink getting repaired to drain completely. On 7/20/23 at approximately 4:00 p.m., an interview was conducted with the Maintenance Assistant. He stated they had did all they knew to do to get the sink in Resident #120's room to drain therefore, he felt it was time to bring in services from the outside. On 7/21/23 at approximately 4:30 p.m., a final interview was conducted with the Administrator, Director of Nursing and Corporate Consultant. They had no further comments and voiced no additional concerns about the non-draining sink in Resident #120's room.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, and a clinical record review, the facility staff failed to ensure a dependent resident's activities of daily living (ADL) were completed for 1 of 59 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 7/19/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; malnutrition, hyperparathyroidism, and chronic atrial fibrillation. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring total care of one person with bathing and toileting, extensive assistance of one person with bed mobility, personal hygiene and dressing, and supervision after set-up with eating. The resident did not transfer or walk. On 7/18/23 at approximately 4:55 p.m., during the initial tour Resident #1 was observed in bed with large white flakes throughout her hair and with long yellow fingernails with some jagged edges. An interview was conducted with Resident #1 on 7/18/23 at approximately 4:58 p.m. The resident stated her fingernails were not cared for because she was required to get out of bed and go down stairs to activities in order to have them filed and painted. The resident also stated her teeth were not brushed and cleaned as often as she desired. Observation of her teeth reveal many broken and discolored teeth. An interview was conducted with the Activities Director on 7/19/23 at approximately 2:10 p.m. The Activities Director stated it is not necessary for a resident to come to an activity for nail care for if they are alerted they will come to the resident. On 7/20/23 at approximately 9:55 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #8, CNA #8 stated it is the assigned CNA's responsibility to wash Resident #1's hair using a shower cap in bed and to provide oral care. CNA #8 also stated the resident does not have to go to activities for nail care for it is provided along with ADL care by the assigned CNA. On 7/21/23 at 9:48 a.m., another interview was conducted with Resident #1, she stated They came in last night filed and painted my fingernails, and washed my hair but the nurse had problems combing my hair out in the back because it was and remains matted. Resident #1 stated her teeth were also brushed before breakfast and her mouth was feeling fresh. On 7/21/23 at approximately 4:30 p.m., a final interview was conducted with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON stated the resident's hair had been shampooed and a medicated shampoo, had been ordered as well as a special mouthwash and her nails had been filed and painted, since the concerns had been brought to their attention.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. The facility staff failed to provide the necessary care and services to monitor, assess and treat one resident timely who presented with sign and symptoms and complications of a Urinary Tract Infection (UTI) for 1 out 59 residents (Resident #46) in the survey sample. The findings included: Resident #46 was originally admitted to the nursing facility on 05/14/21. Diagnosis for Resident #46 included but not limited to acute subdural hemorrhage, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The most recent Minimum Data Set (MDS - an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 06/12/23 coded Resident #46 with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS coded Resident #46 total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, personal hygiene, and toilet use and supervision with one assist with eating for Activities of Daily Living (ADL) care. Resident #46's person-centered care plan created on 05/24/21 and revised on 06/18/23 identified the resident experiences bladder/bowel incontinence at times due to dementia. The goal set for the resident by the staff was that the resident will maintain current level of bladder/bowel incontinence and remain free from signs/symptoms (s/s) of Urinary Tract Infection (UTI). Some of the interventions/approaches the staff would use to accomplish this goal is to report any signs of UTI (acute confusion, urgency, frequently, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low/back/flank pain, malaise, foul odor, concentrated urine and blood in urine), provide cueing/supervision assistance for toileting as needed and provide incontinence care after incontinent episodes as needed. On 05/11/23, Resident #46 complained of stomach pain and was administered Motrin (pain medication) 400 mg. On the same day, Resident #46 urinated on herself and on the bathroom floor. The urine noted to have a foul odor. Resident also observed with increased agitation. The resident was seen by the psych Nurse Practitioner (NP) on 05/11/23 with new orders to obtain Urine Analysis (UA) with Culture and Sensitivity (C&S), Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) in the morning. The psych NP was interviewed on 07/21/23 at 2:51 p.m. He stated he was asked by nursing to evaluated Resident #46 on 05/11/23 for increased agitation/behaviors. He stated he ordered labs for blood work and a UA/C&S to rule out an UTI. He stated he ordered labs on Resident #46 but it's the responsibility of the resident's primary physician to follow-up with treatment. On 05/12/23, a change in condition form was completed on Resident #46. The form identified Resident #46 with increased confusion or disorientation, new or worsened delusions or hallucination and blood-tinged urine. The physician was informed of change in condition. Further review of the clinical record did not reveal a MD or NP visit related to change in condition with Resident #46. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses' notes dated 05/13/23 at 2:05 p.m., revealed Resident #46 observed with intermittent confusion throughout the day. The note indicated lab results for C&S had not been received. The note indicated the physician was notified of Resident #46's intermittent confusion, but he wanted to wait for the final labs (C&S). During the review of Resident #46's nurses' note dated 05/14/23 at 8:23 a.m., indicated the resident was observed lying on the floor in the bathroom with several spots of urine on the floor. Resident #46 had a bowel movement in the commode with blood noted. The note stated hematuria but also document uncertain where the bleeding was coming from. At 12:30 p.m., Resident #46 was administered Motrin 400 mg for complaints of stomach pain. On the same day at 10:17 p.m., Resident observed to have increased agitation to noise, tremors noted, gait unsteady and required two (2) persons assist with care. Further review of the clinical record did not reveal a MD/NP visit or assessment. The nurses' note dated 05/17/23 at 12:58 p.m., indicated the facility was still waiting for the final urine report for the C&S. The note indicated Resident #46 noted to have hematuria with her bowel movement. NP #1 informed Resident #46 observed with increased behaviors, increased leaning to the left side with weakness and the facility was still waiting for the final urine report. On 05/19/23 at 7:22 a.m., the final urine sensitivity report showed the urine organism growing 50,000 (Escherichia coli). The physician was informed with a new order to start Resident #46 on Keflex (antibiotics) 500 mg every 12 hours x 7 days for UTI. On 05/20/23 at 6:47 p.m., Resident urinated on self while in the day room. Resident was assisted to the bathroom where she noted to have small amount of hematuria in the commode. The clinical note indicated on 05/21/23 at 12:07 a.m., Resident #46 had a bowel movement on the toilet with drips of blood noted. A phone interview was conducted with Resident #46's previous physician on 07/21/23 at 11:13 a.m. The nurses' notes and labs dated from 05/10/23 through 05/22/23 were reviewed with the physician. He was informed of the abnormal urine analysis with hematuria, increased confusion, tremors, and stomach pain. He stated the UA showed evidence of an UTI and should have been treated. He stated it's normal to treat prophylactic hoping the right medication was picked. He stated when the urine sensitivity report is obtained and if the wrong medication was prescribed, that medication will be discontinued and antibiotic that is sensitive to the organism growing will be prescribed. A review of Resident #46's clinical note dated 05/17/2023 at 2:35 p.m., revealed the NP #1 was informed Resident #46 continued with signs/symptoms of UTI, with no new orders. On 07/21/23 at 10:31 a.m., a phone interview was conducted with NP #1. She stated even though the C&S had not returned, the UA noted Resident #46 had a UTI. She stated it is normal to treat the older population if they are showing s/s of a UTI which she did. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Norfolk	1005 Hampton Blvd Norfolk, VA 23507

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/21/23 at 4:14 p.m., an interview was conducted with the Director of Nursing (DON) with five (5) other surveyors present who were informed regarding the above findings. She stated when Resident #46 was observed with increased sleeping, reach for objects, tremors, and hematuria, the physician or NP should have been notified. She stated the resident could have had neurological issues, internal bleeding, or possible UTI. She stated Resident #46 needed further evaluation and a clinical assessment by the physician or NP. She stated according to the clinical note written on 05/15/23, Resident #46 was observed with hematuria, the physician or NP should had been notified. She stated the physician or NP was never giving an opportunity to assess or treat Resident #46 for the change in condition. The DON was asked if Resident #46 was evaluated and assessed by physician or NP from 05/12/23 - 05/22/23, she replied, No. She was asked if Resident #46 should have been evaluated related to the continued change in condition, she replied, Absolutely. A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing and [NAME] President of Clinical Operations on 07/21/23 at approximately 5:30 p.m. No further information was provided prior to exit. McGreers definition of Urinary Tract Infection -Urinary tract infection includes only symptomatic urinary tract infections. Surveillance for asymptomatic bacteriuria (defined as the presence of a positive urine culture in the absence of new signs and symptoms or UTI) is not recommended, as this represents baseline status for many residents. Symptomatic urinary tract infection One of the following criteria must be met: The resident does not have an indwelling urinary catheter and has at least three of the following signs and symptoms: -Fever (>38ºC) or chills -New or increased burning pain on urination, frequency or urgency -May be new or increased incontinence -New flank or suprapubic pain or tenderness -Change in character of urine [may be clinical (e.g., bloody urine) or as reported by the laboratory (new pyuria or microscopic hematuria). For laboratory changes a previous urinalysis must have been negative. -Worsening of mental or functional status Definitions -Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. ttp://www.cdc.gov/HAI/ca_uti/uti.html). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI. http://www.webmd.com/a-to-z-guides/urine-culture). -Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure 1 of 59 residents (Resident #236) in the survey sample were free of significant medication errors. The findings included: The facility staff failed to ensure the significant medication Lopressor (used to treat high blood pressure) 25 mg was administered twice a day to Resident #326 from 11/14/20 through 11/20/20. Resident #236 was admitted to the facility on [DATE] and transferred to an acute care setting on 11/24/20. The resident did not return to the nursing facility. Diagnosis included but are not limited to Congestive Heart Failure (CHF) and Hypertension (high blood pressure). Resident #236's Minimum Data Set (MDS - an assessment protocol) an admission assessment with an Assessment Reference Date of 11/17/20 coded Resident #236's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. Resident #236's person-centered care plan created on 11/15/20 and revised on 11/20/20 identified the resident with health-related issues related to cardiovascular, respiratory and diabetes complications. The goal set for the resident by the staff was that the resident will not develop complications. Some of the interventions/approaches the staff would use to accomplish this goal is to start Lopressor 25 mg by mouth twice a day and to administer medication as ordered. A review of Resident #236's hospital Discharge summary dated [DATE] included an order to administer Metoprolol (Lopressor) 25 mg twice a day for high blood pressure. A review of Resident #236's clinical record to include the Physician Order Summary (POS) and Medication Administration Record (MAR) revealed the medication Lopressor was not started until 11/20/20. The clinical record indicated an Event Detail report dated 11/20/20 indicated a medication error related to Resident #236's high blood pressure medication (Lopressor) was not entered into the system on 11/13/20 indicating Resident #236 missed 13 does of her blood pressure medication. Further review of the Event Detail report documents the physician was made aware with a new order to start Lopressor 25 mg twice a day for high blood pressure. An interview was conducted with the Director of Nursing (DON) who was the MDS Coordinator when the medication error occurred on 11/13/20. She stated she was doing a chart audit review when she compared Resident #236's discharge order with the admission orders and discovered the resident's Lopressor 25 mg twice a day was omitted from the admission orders. She stated she immediately informed the physician on 11/20/20 with a new order to start Lopressor 25 mg twice a day. A final meeting was held with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations on 07/21/23 at 5:30 p.m. No further information was provided prior to exit. Definitions: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Congestive Heart Failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath. Certain heart conditions, such as narrowed arteries in the heart (coronary artery disease) or high blood pressure, gradually leave the heart too weak or stiff to fill and pump blood properly (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms). -Hypertension is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high (https://medlineplus.gov/ency/article/007365.htm).