STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Nursing and Rehabilitation Center	1028 Topping Lane Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 28567 Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure that a resident and/or the resident representative had the opportunity to develop an Advanced Directive for 1 of 18 current residents, Resident #16. The findings include: The facility staff failed to provide evidence that they had offered Resident #16 and/or the resident representative the opportunity to develop an Advance Directive. Resident #16's diagnoses included chronic respiratory failure and adult failure to thrive. Section C (cognitive patterns) of Resident #16's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/09/24 included a brief interview for mental status (BIMS) score of 10 out of a possible 15 points. Per the MDS manual a 10=moderate cognitive impairment. During the record review the surveyor was unable to locate any information to indicate this resident and/or the resident representative had been offered the opportunity to develop an Advance Directive. On 10/02/24 at 4:35 p.m., during an end of the day meeting with the Director of Clinical Support, [NAME] President of Quality, Director of Nursing, and [NAME] President of Nursing Services the issue with the missing advance directive information was reviewed. On 10/03/24 at 8:40 a.m., the [NAME] President of Quality stated they were unable to locate advance directive information for this resident. The facility staff provided the surveyor with a copy of a policy titled, ADVANCE DIRECTIVES. This policy read in part, Advanced Directives will be discussed with resident and/or family member upon admission or as soon as clinically appropriate so the resident's wishes, with respect to life prolonging treatments, can be documented in the medical record . No further information regarding this issue was provided to the survey team prior to the exit conference.

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.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 28169 Based on staff interview, clinical record review, facility document review, facility staff failed to provide written notice of transfer for 2 of 18 current residents in the survey sample. (Resident #19 and Resident #36). The findings were: 1. For Resident #19, the facility staff failed to provide the resident representative a written notice of transfer when the resident was transferred to the hospital on 08/02/24 or 09/25/24. The minimum data set assessment with an assessment reference date of 08/25/24 coded the resident a brief interview for mental status (BIMS) score of 11 out of 15 indicating moderately impaired cognition (Section C - cognitive patterns). During a review of Resident #19's clinical record, progress notes read the resident was transferred to a hospital on both 08/02/24 and 09/25/24. A licensed practical nurse (LPN) note dated 08/02/24 at 2:56 a.m. read 911 in to [sic] transport resident to (hospital initials omitted) ER at 2:40 AM. Message was left on (family member name omitted) answering machine asking him to call the facility at his earliest convenience. Another LPN note dated 09/25/24 at 5:10 p.m. read Resident presenting objective Signs [sic] that she may have Sepsis and is Hypotensive with a B/P of 87/61. Son is aware and insist [sic] although the Resident is Comfort Measures that the Resident be sent to the hospital for Eval. and Treatment. Order received from MD to send the Resident 911. 515 pm.[sic] 911 Transport Team in. Resident taken to (hospital name omitted) for treatment. The surveyor was unable to find evidence of written notification to Resident #19's representative of the transfer for both dates. On 10/03/24 at 11:05 a.m., the facility's [NAME] President of Nursing Services and [NAME] President of Quality were interviewed. Both employees reported they were unaware of anyone sending resident representatives written notification of transfer/discharges for emergency transfers, in general. The V.P. of Quality provided the facility's employee with the title of navigator who stated that after residents were admitted to a hospital, she calls the responsible party (RP) and informs them of the bed hold information. The RP usually comes to the facility to pay for the bed hold if they want. The navigator denied sending any written information to residents' representatives regarding transfers to hospitals. On 10/03/24 in the afternoon, the VP of Quality provided documents she stated would be what was sent with the emergency medical services when Resident #19 was transferred to the hospital on both 08/02/24 and 09/25/24. The documents did not contain specific information about where the resident was being transferred to or for what reason. The VP of Quality acknowledged the documents did not contain that specific information. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern regarding no evidence of written notification to the resident representative of Resident #19's transfer to the hospital on 08/02/24 and 09/25/24 was discussed with the Director of Clinical Services, Director of Nursing, [NAME] President of Quality, [NAME] President of Nursing Services and [NAME] President of Clinical Affairs on 10/03/24 at 3:37 p.m. No further information was provided prior to the exit conference. 34307 2. For Resident #36 the facility staff failed to provide written notice of transfer to the hospital. Resident #36's face sheet listed diagnoses which included but not limited to sepsis, heart failure and dementia. Resident #36's most recent minimum data set with an assessment reference date of 09/20/24 assigned the resident a brief interview for mental status score of 7 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively intact. Resident #36's clinical record was reviewed and contained a nurse's progress note dated 09/25/24 at 12:29 am which read in part, 11:10 pm-resident lying in the bed with eyes open, and eyes are rolling back in her head. 02 sats are 88% on room are, vital signs are 121/78-102.9, 70, 24 (blood pressure, temperature, pulse, respirations). Resident was put on 2 liters of oxygen, and 02 came up to 94%. She had high fever, difficult breathing and altered mental status. 911 called. MD made aware. Attempted to notify son but no answer received so voice message left for him to call facility. Did talk to resident's sister who wanted resident transferred to . (name omitted) and stated she would meet them there. Surveyor reviewed resident's clinical record and could not locate any information that a written notice of transfer was provided to the resident's responsible party (RP). Surveyor spoke with the vice-president of quality and vice-president of nursing services on 10/03/24 at 11:05 am regarding Resident #36's hospital transfer information. These two staff provided surveyor with a copy of Transfer Clinical Summary dated 09/25/24 which included a Notice of Transfer. This portion of the transfer summary did not include a date, location resident was transferred to, or reason for transfer. Vice-president of quality stated this form is only sent to the receiving facility. Surveyor spoke with the resident navigator on 10/03/24 at 11:20 am. Resident navigator stated they were not providing written notification of transfer/discharge to the resident's RP when a resident is sent out to the hospital. Surveyor requested and was provided with a facility policy entitled, Admission, Transfer & Discharge Rights Policy which read in part, Notice before transfer. Before a resident is transferred or discharged , the facility will notify the resident, and if known, the resident representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. This notice shall be in writing and shall include the reason for transfer. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not providing written notification of transfer/discharge to the resident's RP was discussed with the vice-president of nursing services, vice-president of quality, and director of nursing on 10/03/24 at 3 pm. No further information was provided prior to exit.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 28169 2. For Resident #19, the facility staff failed to provide the resident representative a written notice which specifies the duration of the bed hold policy when the resident was transferred to the hospital on 08/02/24 or 09/25/24. The minimum data set assessment with an assessment reference date of 08/25/24 coded the resident a brief interview for mental status (BIMS) score of 11 out of 15 indicating moderately impaired cognition (Section C - cognitive patterns). During a review of Resident #19's clinical record, progress notes read the resident was transferred to a hospital on both 08/02/24 and 09/25/24. A licensed practical nurse (LPN) note dated 08/02/24 at 2:56 a.m. read 911 in to [sic] transport resident to (hospital initials omitted) ER at 2:40 AM. Message was left on (family member name omitted) answering machine asking him to call the facility at his earliest convenience. Another LPN note dated 09/25/24 at 5:10 p.m. read Resident presenting objective Signs [sic] that she may have Sepsis and is Hypotensive with a B/P of 87/61. Son is aware and insist [sic] although the Resident is Comfort Measures that the Resident be sent to the hospital for Eval. and Treatment. Order received from MD to send the Resident 911. 515 pm.[sic] 911 Transport Team in. Resident taken to (hospital name omitted) for treatment. The surveyor was unable to find evidence of written notification to Resident #19's representative of the facility's bed hold policy for both dates. On 10/03/24 at 11:05 a.m., the facility's [NAME] President of Nursing Services and [NAME] President of Quality were interviewed. Both employees reported they were unaware of anyone sending resident representatives written notification of the bed hold policy for emergency transfers, in general. The V.P. of Quality provided the facility's employee with the title of navigator who stated that after residents were admitted to a hospital, she calls the responsible party (RP) and informs them of the bed hold information. The RP usually comes to the facility to pay for the bed hold if they want. The navigator denied sending any written information to residents' representatives which specifies the duration of the bed hold policy when the resident was transferred to the hospital on 08/02/24 or 09/25/24. The concern regarding no evidence of written notification of the bed hold policy provided to Resident #19's representative when the resident was transferred to the hospital on 08/02/24 and 09/25/24 was discussed with the Director of Clinical Services, Director of Nursing, [NAME] President of Quality, [NAME] President of Nursing Services and [NAME] President of Clinical Affairs on 10/03/24 at 3:37 p.m. No further information was provided prior to the exit conference. 34307 Based on staff interview, clinical record review and facility policy review the facility staff failed to provide written notice of bed hold policy for 2 of 18 residents, Resident #36 and Resident #19. The findings included: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. For Resident #36 the facility staff failed to provide written notice of bed hold. Resident #36's face sheet listed diagnoses which included but not limited to sepsis, heart failure and dementia. Resident #36's most recent minimum data set with an assessment reference date of 09/20/24 assigned the resident a brief interview for mental status score of 7 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively intact. Resident #36's clinical record was reviewed and contained a nurse's progress note dated 09/25/24 at 12:29 am which read in part, 11:10 pm-resident lying in the bed with eyes open, and eyes are rolling back in her head. 02 sats are 88% on room are, vital signs are 121/78-102.9, 70, 24 (blood pressure, temperature, pulse, respirations). Resident was put on 2 liters of oxygen, and 02 came up to 94%. She had high fever, difficult breathing and altered mental status. 911 called. MD made aware. Attempted to notify son but no answer received so voice message left for him to call facility. Did talk to resident's sister who wanted resident transferred to . (name omitted) and stated she would meet them there. Surveyor reviewed resident's clinical record and could not locate any information that information related to bed hold was provided to the resident/responsible party. Surveyor spoke with the vice-president of quality and vice-president of nursing services on 10/03/24 at 11:05 am regarding Resident #36's hospital transfer information. These two staff provided surveyor with a copy of Transfer Clinical Summary dated 09/25/24 which included a Bed Hold Policy Notice. This notice did not include information on duration of bed hold or information on reserve payment. Surveyor spoke with the resident navigator on 10/03/24 at 11:20 am. Resident navigator stated they call the resident's RP if the resident is admitted to the hospital, with information on duration of bed hold and payment amount. Resident navigator stated if family want to do a bed hold, they come into the facility and sign the agreement, and pay for the bed hold. Surveyor requested and was provided with a facility policy entitled, Admission, Transfer & Discharge Rights Policy which read in part, Notice of bed-hold policy and return. If a resident requires transfer to an acute hospital, the facility will offer the resident the opportunity of electing to have the bed held. Upon admission, the facility will notify the resident or the resident's representative of the bed-hold option. If the bed-hold option is exercised, the resident or the resident's representative is liable to pay reasonable charges, not to exceed the resident's daily room rate, for the bed-hold period. Before a resident is transferred to a hospital or goes on therapeutic leave, the facility will provide written information to the resident or resident representative specifying: 2. A notice that includes the items provided in the Notice of Transfer and Contents of Notice sections. The concern of not providing written notification of bed hold to the resident/RP was discussed with the vice-president of nursing, vice-president of quality and director of nursing on 10/03/24 at 3 pm. No further information was provided prior to exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 28567 Based on observation, staff interview, facility document review, the facility staff failed to ensure narcotics were secured in a permanently affixed compartment on 1 of 2 units, the [NAME] unit. The findings include: The facility staff failed to provide a permanently affixed compartment for narcotics on the [NAME] unit On 10/02/24 at 3:40 p.m., the surveyor and Licensed Practical Nurse (LPN) #3 checked the medication refrigerator on the [NAME] unit. This refrigerator contained a locked black metal box. The surveyor was able to remove this box from the refrigerator and place it on the counter. LPN #3 unlocked the box, and it was observed to contain 5 vials of 1 ml Lorazepam. On 10/02/24 at 4:05 p.m., the [NAME] President of Quality provided the surveyor with a copy of their policy titled, Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles. This policy read in part, Medications, biologicals, syringes, and needles are stored under proper conditions as directed by state and federal regulations and manufacturer guidelines to ensure their stability, quality, safety, and security . On 10/02/24 at 4:35 p.m., during an end of the day meeting with the Director of Clinical Support, [NAME] President of Quality, Director of Nursing, and [NAME] President of Nursing Services the issue with the unsecured narcotic box was reviewed. On 10/03/24 at 8:40 a.m., the [NAME] President of Quality stated they had secured the narcotic box. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to assist residents in obtaining dental care from an outside source for 1 of 18 sampled residents, Resident #1. The findings included: For Resident #1, the facility staff failed to obtain a dental consult. Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Spastic Hemiplegia Cerebral Palsy, Epilepsy, and Thrombocytopenia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/22/24 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating the resident was severely cognitively impaired. A review of Resident #1's clinical record revealed the following documentation: A nursing progress note dated 5/30/23 at 3:19 PM read Resident [adult child] in facility and said [their] mom's mouth hurts. Writer let PA [physician's assistant] [name omitted] know . Resident #1 was seen by the PA the following day on 5/31/23. The progress note read in part On exam, [his/her] mouth is bloody as [he/she] just received oral care and gums are bleeding .Gingivitis .referral for dental evaluation . Resident #1 was again seen by the PA on 6/02/23, the progress note read in part .F/u [follow-up] gingival Bleeding - No bleeding today but gums are still very irritated. The RU [right upper] gingival line is swollen with white plaque . Resident #1 was seen by the PA on 6/05/23, the progress note read in part .F/u gingival Bleeding - bleeding still present per CNA [Certified Nursing Assistant] this morning. Excessive plaque and gingival irritation along with thrombocytopenia 2/2 [secondary] to Keppra makes them bleed more than they typically would .gums inflamed, caries present, white plaque on right lateral incisor .Gingivitis .awaiting referral to dentist . On 10/03/24, surveyor reviewed Resident #1's clinical record and was unable to locate evidence of a dental referral for the resident. On 10/03/24 at 9:50 AM, surveyor spoke with the Director of Nursing (DON) regarding the dental referral. The DON stated an order for the dental consult was never entered into the record by the provider and that was how staff were made aware to schedule an appointment and arrange transportation. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with the PA via telephone on 10/03/24 at 1:48 PM regarding the dental referral. PA stated Resident #1 had a lot of buildup and their mouth was getting worse, but Peridex was helping. PA stated it was difficult to get a dental appointment and transportation, but they needed to at least attempt it. PA stated they did not know what happened on the other side of a referral after the order goes in, but the process has improved by leaps and bounds as she now notifies the person responsible for setting up consults when she places an order. PA stated prior to this change she had noticed a couple referral orders did not go through. Surveyor requested and received the facility policy titled Administration Policy with a reviewed/revised date of 7/21/23 which read in part .Services not provided by a qualified professional employee of the facility shall be furnished to residents by a person or agency outside the facility under an arrangement. Arrangements for services to residents specify (in writing) that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing the services. The facility also assumes responsibility for the timeliness of the services provided under an arrangement. On 10/03/24 at 3:36 PM, the survey team met with the Administrator, [NAME] President (VP) of Clinical Affairs, VP of Quality, VP of Nursing Services, DON, and Director of Clinical Support and discussed the concern of staff failing to obtain a dental consult for Resident #1. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/03/24.

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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. 28567 Based on observation and staff interview, the facility staff failed to prepare, distribute, and serve food in a manner that would prevent foodborne illnesses. The wash cycle of the dish machine was not working properly. The findings include: The facility staff failed to ensure the dish machine was in working order. The wash cycle failed to reach a temperature of 120 degrees. On 10/01/24 at approximately 9:50 a.m., the surveyor observed two dietary staff (dietary employee #1 and #2) running the dish machine in the facility kitchen. The surveyor approached the staff and observed these staff to run the dish machine three additional times. During these observations the wash cycle never went over 112 degrees. The directions on the dish machine read minimum wash cycle 120 degrees. The dietary manager identified this machine as a low temperature machine and stated they would call maintenance and hand wash the dishes. On 10/01/24 at 12:00 p.m., the Maintenance Director (MD) was observed working on the dish machine. The MD stated they had cut the temperature up on the hot water heater and cleaned the temperature sensor. During this observation the wash cycle temperature was observed to reach 120 degrees. During an end of the day meeting on 10/01/24 at 5:15 p.m., with the [NAME] President of Operations, Director of Nursing, [NAME] President of Nursing Services, and Director of Clinical Support, the issue with the dish machine not reaching the correct wash temperature was reviewed. The surveyor attempted to interview dietary employee #1 on 10/03/24 at 9:10 a.m. but was unsuccessful. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview and facility document review, the facility staff failed to provide evidence of staff education regarding activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, abuse prevention, procedures for reporting incidents of abuse and dementia management for 1 of 5 staff members reviewed, Certified Nursing Assistant (CNA) #5. The findings included: The facility staff were unable to provide evidence of staff education regarding prevention, identification, and procedures for reporting resident abuse and dementia management for CNA #5. On 10/03/24, surveyor requested evidence of CNA #5's staff education completed since hire. CNA #5 had been employed with the facility since September 2023. On 10/03/24 at 2:20 PM, surveyor spoke with the [NAME] President (VP) of Quality and VP of Nursing Services regarding CNA #5's education records. VP of Quality stated they could not locate any training records since hire for CNA #5. VP of Nursing Services stated the CNA had been removed from the schedule and could not return to work until all required trainings were completed. Surveyor requested and received the facility policy titled Resident Abuse Prevention with a last reviewed date of 11/07/22 which read in part .Upon hire and at least annually, staff will be trained regarding abuse, neglect, misappropriation of resident property, and exploitation . The Facility assessment dated [DATE] read in part .Required in-service training for nurse aides. In-service training must .Include dementia management training and resident abuse prevention training . On 10/03/24 at 3:36 PM, the survey team met with the VP of Quality, Director of Clinical Support, VP of Nursing Services, VP of Clinical Affairs, and the Director of Nursing and discussed the concern of CNA #5 failing to receive education regarding resident abuse and dementia management. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/03/24.

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview and facility document review, the facility staff failed to provide evidence of a minimum of 12 hours of annual training for 1 of 5 sampled Certified Nursing Assistants (CNA), CNA #5. The findings included: The facility staff were unable to provide evidence of at least 12 hours of annual training for CNA #5. On 10/03/24, surveyor requested evidence of CNA #5's staff trainings completed since hire. CNA #5 had been employed with the facility since September 2023. On 10/03/24 at 2:20 PM, surveyor spoke with the [NAME] President (VP) of Quality and VP of Nursing Services regarding CNA #5's training records. VP of Quality stated they could not locate any training records since hire for CNA #5. VP of Nursing Services stated the CNA had been removed from the schedule and could not return to work until all required trainings were completed. Surveyor requested and received the Facility assessment dated [DATE] which read in part .Required in-service training for nurse aides. In-service training must: - Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year . On 10/03/24 at 3:36 PM, the survey team met with the VP of Quality, Director of Clinical Support, VP of Nursing Services, VP of Clinical Affairs, and the Director of Nursing and discussed the concern of CNA #5 failing to receive at least 12 hours of annual training. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/03/24.