STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	485000	A. BUILDING _____ B. WING _____	**09/13/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA VIEW NURSING HOME	**7500 BOLONGO BAY ST THOMAS, VI 00802**

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 0226 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility complaints and investigations, and resident and staff interviews, it was determined that the facility failed to protect 1 of 14 residents (Resident #7) from physical abuse inflicted by staff and that caused the resident to sustain an injury. The findings are: Resident #7 is a [AGE] year old female diagnosed with [REDACTED]. Nursing Monthly Summary Assessments dated 7/1/2013, 8/1/2013 and 9/1/2013 indicate the resident is alert but confused, speaks incoherently, and requires assistance with transfers. The resident is non-ambulatory and uses a wheelchair. A complaint investigation dated 8/28/2013 identifies the resident as a victim of physical abuse. During review of the resident's medical record a nursing note documented on Clinical Notes dated 8/22/2013 at 5:30 P.M. were observed to read: I was made aware of a small cut to the resident's forehead. The area was cleaned ad a bandage applied; Incident report written. A second entry written for 1-3:00 A.M., reads: Met resident in bed asleep.bandage to forehead, slight swelling noted. A review of an Incident Report dated 8/22 /2013 reveals the resident sustained [REDACTED]. The incident report provides the following description of occurrence: A fight between two employees; Resident # 7 was found with a small cut to the forehead. Area was cleaned and antibiotics applied and covered with a bandage. An investigative Report dated 8/28/2013 summarizes the incident as follows: On August 22, 2013, it was reported that there was an altercation between a CNA and a housekeeper which started as a result of a resident's family member asking to have some fruit placed in the refrigerator. According to witnesses of the incident, the CNA questioned whether or not the fruit was labeled. The housekeeper said yes, they were, and felt that the CNA was harassing her. According to the LPN Charge nurse, she overheard the housekeeper asking the CNA to excuse (move away from) behind the nursing station in order for her to sweep and mop. The CNA was asked three times and refused to move until the nurse intervened and ordered her to move. The CNA left from behind the nurse's station and the housekeeper proceeded to sweep. At the same time the phone rang and the housekeeper answered it. The CNA told her not to answer the phone again and proceeded to pull the phone away from the housekeeper. In the altercation of the phone incident, a resident was physically hurt. She received a blow to the forehead which left a red mark and a small amount of swelling. The resident was immediately removed from the scene while the two staff members continued to fight. Further investigation with the evening shift revealed that both employees were arguing before the fight occurred. During an interview with the facility ' s administrator conducted 9/12/2013 at 1:15 P.M., the administrator stated that she made a thorough investigation of the incident and both parties admitted that they were fighting which is against the facility ' s policy. The fighting occurred in front of residents and Resident #7 was hurt. The administrator also stated that it is the Nursing Home's policy that fighting in the work place will not be tolerated and if a resident is hurt in the process of employees fighting, it will be considered physical abuse of that resident. The administrator stated both employees admitted to hitting the resident with the phone during the fight which caused swelling and a red mark to the Resident's forehead. The administrator also stated that she has had problems with these two employees in the past. The Housekeeping Director was interviewed on 9/12/2013 at approximately 3:00 P.M. and reported during the interview that the housekeeper involved in the fight was a problem and had been a problem for a long time. He stated the employee was difficult to manage, would not follow orders, and did whatever she wanted. He further stated that the she (the housekeeper) has been involved in a previous incident of verbal fighting that occurred with another staff member right outside of resident rooms. He stated the housekeeper was screaming out derogatory words and everyone including the residents could hear her. She thinks she can do whatever she wants because she's worked here for so long. During the resident Group Meeting held 9/10/2013, when residents were asked about incidence of abuse, one resident in the group, Resident #14 reported that about three weeks ago, he observed a fight between two of the staff that occurred at the nurse's station. An individual interview was held with Resident #14 on 9/12/2013 at 10:30 A.M. The resident reported that during the fight he witnessed between the two staff members about three weeks ago, a resident who was sitting in a wheelchair near the nurse's station was hurt when she was hit in the head with the telephone. The resident stated the staff was fighting over the telephone. He said he was not the only one to witness the incident. Everyone saw it. Personnel files of the CNA and Housekeeper were reviewed on 9/12/2013. Each file revealed a history of multiple incidents of violent verbal behavior. Disciplinary Notices that were found in the CNA's file indicate the CNA was counseled for verbal abuse and use of profanity in front of residents on several occasions from 5/10/07 through 4/28/12. On 5/14/07, the CNA was counseled and received a Letter of Warning for an act of insubordination and abusive behavior directed at a Charge Nurse occurring at the Nurses' station 5/10/07. On 11/23/09, she was counseled for verbal abuse and harassment of other employees /coworkers. On 1/27/10, she was counseled for Job and resident abandonment and on 5/31/11 she was counseled for becoming irate and verbally assaulting the Administrator during a staff meeting. A warning notice, documented by the Director of Nurses, reveals that on on 5/31/11, the CNA was on sick leave. She was, however, in the facility and decided to attend the monthly staff meeting. During the course of the discussion, she became very irate and began a verbal assault on the Administrator. I immediately informed her that her behavior was unacceptable and disrespectful to the Administrator as well as all others in attendance and would not be tolerated. She was asked to cease the behavior, but instead, her behavior escalated and her tirade of negative remarks continued. This resulted in disruption of the staff meeting. She was then asked to leave the meeting and the facility but did not do so until she was finished with her verbal assault. I have spoken with the CNA on several occasions regarding her inappropriate behaviors - specifically outbursts that have incited the staff. She has been asked to discuss any matters which she is not in agreement with instead of making negative comments or engaging in loud outbursts in the presence of everyone. In spite of this, she continues to do so. A disciplinary action notice dated 3/14/2012 documented by the Director of Nursing reveals that on 3/8/12, outside the door of a resident 's room, and within hearing distance of residents, the CNA and another housekeeper verbally abused each other with derogatory terms. Letters warning of suspension and /or termination are documented in this employee file for each incident since the initial episode that occurred in 2007. There was no evidence found in the CNA's file to indicate that either of these interventions was implemented. A Review of the Housekeeper's personnel record reveals that she was initially hired as a cook in 1998 was terminated in 1999 for insubordination and serving residents improperly cooked food (raw food), was rehired as a laundry attendant and subsequently transferred to housekeeping. She has received the following Disciplinary Action Notices since her date of hire and prior to the violent physical incident that occurred on 8/22/2013: On 2/22/1999 she was counseled for insubordination and unsafe food preparation. Documentation on a Performance Improvement Disciplinary Action Plan dated 4/8/99 indicates that on 3/26/1999 and 3/28/1999 the employee committed various food handling infractions which presented a health risk to residents. The problems have been continuous as documented on 2/22/99 and 3/23-3/24/2099. Ongoing counseling has been provided to the employee since 1/25/99. On 4/13/1999, the employee received a Personnel Action Termination Notice

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	485000	A. BUILDING _____ B. WING _____	**09/13/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA VIEW NURSING HOME	**7500 BOLONGO BAY ST THOMAS, VI 00802**

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 0226 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) indicating she is not appropriate for Dietary Services. On 5/22/2001, the employee was counseled for improperly cleaning resident rooms. On 1/9/2002 the employee received a verbal warning for insubordination when she refused to participate in an investigation of resident abuse and neglect. 3/7/2002, a Suspension Notice was given the employee for insubordination when she refused to participate in an investigation of misappropriation of resident's property. 1/13/2010, the Housekeeper was counseled for a violent verbal outburst occurring within the vicinity of resident rooms. A description of this incident is reported by a witness on a document titled Afternoon Disturbance and reads Yesterday, while completing some work on the computer in the MDS room, I heard some loud noise coming from outside. I ignored it for a few minutes until the yelling was getting louder and louder, and at this time heading toward the B Wing where the residents reside. I took a glance outside and saw the Housekeeper loudly cursing and repeatedly saying ya'll please leave me alone. I then addressed her and asked her to lower her tone. The noise down the hallway was definitely disturbing the residents. At that point she asked me to mind my business and leave her alone. I then told her that whatever issue she has, it doesn ' t need to affect those who reside here. Again, she got louder and I resorted to closing the MDS door. Other staff members were asking her to lower her voice, but she just kept getting louder. On 11/30/2010, a Verbal Warning was given for time fraud. ON 12/8/2010, a Written Warning and counseling was given for insubordination and the use of disrespectful language when speaking to her supervisor. On 1/12/2011, the employee received a written warning for an incident of Violent Verbal outbursts that occurred in the presence of residents and was directed at a supervisor. This incident was witnessed by five co-workers who documented the following observations: Witness #1: I was standing at the nurse ' s area when I heard the Housekeeper screaming at the top of her voice, leave me alone! Witness #2: I was in the Nurses ' area when the housekeeper was yelling and making a lot of noise. Ms. ? (Nursing Supervisor) told her to quiet down and she made a remark to her Don't tell me Nothing. She was walking toward the B-Wing and Ms. (Nursing Supervisor) told her to cool down and she made another remark to her saying leave me alone! Witness #3: I was standing at the Nurse's station when I heard the Housekeeper Screaming at the top of her voice, leave me alone. Leave me alone! Witness #4: I found this behavior to be very disruptive and in the presence of residents. I think this needs to be addressed. On 2/8/2011, a Written Warning was given for verbal violence and insubordination by refusing to obey her supervisor directives, engaging in loud arguing with the supervisor and causing a disturbance to residents. The Housekeeper received another Verbal Warning 4/14/2011 for insubordination and refusing to follow her supervisor's orders. This incident was witnessed by two co-workers who documented the following on Witness Statements dated 2/8/2011: Statement#1: On Tuesday, February 8, 2011 at around 2:25 P.M., I was in room A07 (a resident ' s room) cleaning and removing trash from the room when I heard loud arguing on the floor. I came outside the room and I heard the Housekeeper saying to her Supervisor, leave me alone. Don ' t tell me what to do. You don't have anything better to do? Just leave me alone! The Supervisor asked her to please calm down with the loud noise on the floor. She continued to tell him to leave her alone, don't tell me what to do. He repeatedly asked her to stop making noise in the building and she continued in her loud voice, so he walked away. Statement #2: I heard the Housekeeper on the floor saying to leave her alone and she was so loud on the floor. She has no respect for her boss. The Housekeeper received another verbal Warming 4/14/11 for insubordination and refusing to follow her supervisor ' s order. 3/29/2012, a Written Warning was given for verbal abuse directed at another employee, and for using inappropriate language in the resident ' s lounge in the presence of residents. 4/28/2012 the employee was cited for verbal abuse directed at a co-worker and use of profanity in the presence of residents, and on 8/29/2012, a Written Warning was received for violent verbal outbursts and blatant refusal to obey a supervisor ' s orders. In spite of these multiple incidents, the housekeeper remained employed by the facility. The facility ' s Policy for Abuse Prevention includes specific conduct violations that warn its staff of immediate termination. The first violation listed on this Code of Conduct is any verbal or physical abuse to any resident or fell ow employee. This policy was not implemented. In spite of the evidence contained in both employees ' personnel files, they were allowed to continue working until resident # 7 was harmed on 8/22/2013. As a result, the facility was unable to maintain a violence-free workplace, did not protect residents from exposure to violence, and failed to protect one resident from an injury caused by the violent actions of two of its staff. The facility failed to operationalize its Abuse Prevention program.
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview and record review, it was determined that the facility failed to maintain residents appearance in a manner that promotes their dignity. The findings are: Resident # 9 is a [AGE] year-old male diagnosed with [REDACTED]. Care Plans for Dementia, documented 7/2013, indicate the resident is Aphasic, cognitively impaired, hearing impaired and requires total care for all ADLs. On 9/9/2013, at 9:40 A.M., the resident was observed during the initial unit tour lying supine in bed. The door to the resident ' s room was open, his bedside curtain was not drawn, and the resident was uncovered. A bed sheet was hanging off of the foot of the bed and the resident ' s lower body was exposed. The resident was observed to wear a hospital type gown that was pulled up to his torso and he was wearing an adult diaper. The resident ' s feet were exposed and revealed extremely elongated, mycotic toenails. The resident's fingernails were also extremely elongated and mycotic. An interview was held immediately with the nurse accompanying the surveyor who stated the staff needs to check this resident more frequently to make sure he stays covered because he ' s very restless, he pulls his covers off a lot and he should not be exposed. When the nurse was asked about the condition of the resident's finger and toenails, she explained the cutting of residents' fingernails is the responsibility of the Nursing Director and the Doctor is responsible for cutting everyone's toenails. I don't know why they were not done. They should be cut every three months. On 9/9/2013 at 10:00 A.M., during the interview conducted with the Director of Nursing to discuss resident #9 ' s care, the Nursing Director explained the facility maintains a monthly list of residents who require fingernail and toenail cutting. Residents are scheduled each month, and after the list is completed, it is signed off by the doctor and by the charge nurse or by me to indicate the residents nails were cut. The doctor cuts all of the resident's toenails and I cut the fingernails. I'm sure that resident (#9) had his nails cut about three months ago. I can check the list, but I know he's on the list for the Doctor for this month. The fingernail/toenail cutting schedules for the past six months were requested but were not immediately available for review. When presented, they were observed to not have been signed off by either the physician or a nurse to indicate each resident on the list had been groomed. Resident #9 was listed on the monthly schedules for November, 2012, February 2013, May 2013, and August 2013. On 9/9/2013 at approximately 5:00 P.M. the Director of nursing informed the surveyor that she had just attempted to cut resident #9's fingernails, but they were too thick and required a larger toenail cutter than the one size available in the facility. The DON stated she would have to find a larger size. During the Quality of life Assessment Interview held with residents on 9/10/2013 at 10:30 A.M., 5 of the 5 residents in attendance complained of having to wait for as long as 6 months before their finger and toenails were cut. The Attending Physician, responsible for grooming resident toenails was interviewed 9/11/2013 at approximately 11:00 A.M. and reported to the surveyor that he came in to cut Resident #9 ' s toenails but was unable to do so in the usual manner because the toenails were too mycotic and a special instrument was required. Cross refer F-312
F 0244 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Listen to the resident or family groups or act on their complaints or suggestions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to actively respond to a grievance regarding delayed meals presented by the residents at a resident council meeting. This was identified during a group meeting for 5 of 5 alert and oriented residents from 2 of 2 nursing units. This deficient practice was evidenced by the following: In preparation for the Quality of Life Assessment Group Interview the resident council minutes were reviewed from January 2013 through July 2013 and revealed that the issue of a long wait time for meals distribution was discussed in May and June. A review of the facility's Resident Council Concern Sheet used to follow-up on grievances did not reveal that the facility had responded to the resident ' s complaint of late meal delivery for either May or June of 2013. Resident Grievance files dated 03/20/2013 contain a complaint that indicates Food trays come to the unit, but there is a long wait/lag time before the trays are distributed and then the food is cold. There were no attached comments to indicate that the facility had responded to this grievance. During a group meeting conducted on 09/10/13 at 10:30 a.m., when asked Do you receive your breakfast, lunch and dinner on time? Four of five residents stated most of the time it's late. When asked how long beyond the scheduled time do the meals arrive? Four of the five residents attending stated, at least 30 minutes from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	485000	A. BUILDING _____ B. WING _____	**09/13/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA VIEW NURSING HOME	**7500 BOLONGO BAY ST THOMAS, VI 00802**

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 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the scheduled meal time. They all concurred that this practice occurs for all three meals. One of the residents told the surveyor, I am a Diabetic and take Insulin so this is not good for me (referring to the late meal distribution). The surveyor reviewed the record of this resident (resident #1), which revealed that the resident is an Insulin Dependent Diabetic. It further revealed that this resident was recently re-admitted to the facility on [DATE] following an acute hospitalization stay and is documented to have experienced a significant weight loss. During an interview conducted on 9/10/13 at approximately 12:15 PM with the Registered Dietitian (RD) it was revealed that the Kitchen serves both the Adolescent facility and the Nursing Home. When asked directly about the complaint of a long wait/lag time for meal distribution, the Registered Dietician stated the residents get the food late because the kids come first because they have to go to school. When interviewed on the afternoon of 09/11/13 regarding the Adolescents being fed before the Nursing home residents, the Administrator stated she was unaware that this was occurring and that the Adult resident should always be fed first. The Medical Director was interviewed 09/12/13 and stated he was not aware that the Adolescent facility was being served meals before the Nursing residents. This should never occur, these are separate facilities and the Nursing Home residents should always receive their meals first.
F 0250 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** Based on observation, interview and record review, it was determined that the facility failed to provide effective medically-related social services to assist residents to maintain their highest practicable physical, medical and psychosocial well-being. The findings are: A group meeting was held with alert and oriented residents on 9/10/2013 at 10:30 A.M. 5 of the 5 residents in attendance stated in response to questions about the social worker, that they did not know the name of the social worker employed by the facility. 4 residents stated they had never met or been visited by a social worker, and 4 of the 5 residents complained they had never received assistance from a social worker to resolve any social service needs. Each resident in the Group stated, whenever they needed help with a problem, they consulted the Activities Director. Resident #12 complained of requiring assistance with his immigration status. The resident stated he did not receive any money from any source because he was having problems with renewal of his green card. The resident stated, as a result, he has not had any money, not even one dollar of his own, to put into his pocket for the past three years. The resident stated he has requested help with this problem, but no one has helped him. One resident in the group, Resident # 13, complained of not receiving any money from any source for the past two years. The resident stated he had spoken to nursing staff about this problem and it still was not resolved. This resident stated he had not met with a social worker to discuss this issue. He stated he did not know there was a Social Worker in the facility. Resident #13 also complained of the lack of response to his request for discharge from the facility. The resident explained he needed to return to his home to help care for his ill brother. He stated that although he had shared this concern with staff, he had not received assistance from anyone to facilitate his discharge. The resident stated he has not been seen by a Social Worker to discuss his concerns. The medical record of each of the above residents, #12 and # 13 were reviewed on 9/10/13. There was no evidence found in each of these records to indicate a Social worker had responded to their individual concerns. During a meeting with the Director of Nursing on 9/10/13 at 12:15 P.M., when the Surveyors requested to meet with the facility ' s Social Worker, the Director of Nursing stated the Social Worker was not on site. The Nursing Director stated the Social Worker would not be available to meet with the survey team until Wednesday evening when he was scheduled to come to the facility. A telephone interview was held with the Social Worker on 9/10/15 at 2: 00 P.M. During this interview the Social Worker confirmed that he worked for the facility Monday, Wednesday and Thursday evenings. He explained that he was employed full-time at another agency and made time to see residents at the nursing home on those three evenings a week. He stated he has been employed part-time by the facility for several years. During this telephone contact, the Social Worker was interviewed regarding Resident #12 ' s Immigration Green Card concern. The Social Worker informed the surveyor that he was assisting the resident with this problem. When asked about the lack of Social Worker documentation in the resident's chart, the Social Worker explained there was no evidence of his involvement documented in the resident's chart at the Nursing Home because he has the information in a file in his office at his other place of work. The Social Worker was interviewed regarding Resident #13's financial concern and he stated he wasn't sure if the resident was eligible for any funding. The Social Worker offered no explanation for the lack of documentation in the Resident's chart to indicate he had addressed this concern. The Social Worker acknowledged that he was aware of Resident #13's request for discharge and stated that an effort was made 3 or four months ago to send him to his family, but no one was willing to take responsibility. The Social Worker could offer no explanation for the lack of documentation in either the Social Work progress notes or Interdisciplinary notes to indicate He had attempted to address this problem. During an individual interview held with Resident #5 on 9/11/20 13 at 6:00 P.M., the resident discussed her discharge plans with the surveyor. The resident stated she was a bit concerned about returning home without help as she lived alone. The resident stated a member of her family was helping her to make arrangements to return home. The resident stated she was not aware that the facility had a social worker and had never received a visit from a Social Worker to discuss her discharge plans or concerns. The resident stated, but, I would like to speak with one as soon as possible. A telephone interview was conducted with the resident ' s family on 9/12/13 at 11:30 A.M. This family member stated she was making arrangements for the resident to return home as quickly as possible as that is her desire. She stated the resident was due for discharge in a few days and would be returning to her own home where she lives alone. The family member said the resident will need some assistance during the day due to her developing confusion, and she was not sure who could provide that service. She stated she had never seen a Social Worker during her visits to the facility, had not received a telephone call from the Social Worker, and had not received help from the Social Worker to assist her with the resident ' s discharge plan. The resident's medical record was reviewed 9/11/13 and was found to not contain evidence of the Social Worker ' s involvement with this resident's discharge. During an interview with the Director of Nursing Services to investigate resident complaints, the DON explained that the Social Worker comes to the facility part-time in the evenings because he has a full-time job during the day. She stated the Social Worker set his own hours and was scheduled to work on Monday, Wednesday and Thursday evenings from about 6 P.M until 9 P.M. The DON acknowledged that most of the residents began to prepare for bed at around 6 to 7 P.M., after finishing their dinner meal. An interview to discuss resident concerns was held with the Administrator on 9/11/2013 at 1:45 P.M. The Administrator explained that it was difficult for the facility to find qualified Social Workers. She stated the social Worker employed by the facility does come in for a few hours in the evenings. The Administrator stated the Social Worker does make sure the residents Medicaid certifications were completed and did sign off on the MDS. The Administrator did acknowledge that most residents began to prepare for bed around 6:30 P.M. following completion of the evening meal. On Wednesday 9/11/13, although the Survey team remained in the facility until 7:30 P.M., the Social Worker did not appear on site as scheduled. At least one resident, Resident#5 awaited his arrival. The Director of Nursing confirmed on 9/12/2013, the next morning that the Social Worker did not come to the facility at all during the previous evening.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficient practice was noted for one of 14 sampled residents. The findings are: Resident # 9 is a [AGE] year-old male diagnosed with [REDACTED]. Care Plans for Dementia, documented 7/2013, indicate the resident is Aphasic, cognitively impaired, hearing impaired and requires total care for all ADLs. On 9/9/2013, at 9:40 A.M., the resident was observed during the initial unit tour lying supine in bed. The door to the resident ' s room was open, his bedside curtain was not drawn, and the resident was uncovered. A bed sheet was hanging off of the foot of the bed and the resident ' s lower body was exposed. The resident was observed to wear a hospital type gown that was pulled up to his torso and he was wearing an adult diaper. The resident's feet were exposed and revealed extremely elongated, mycotic toenails. The resident's fingernails were also extremely elongated and mycotic. An interview was held immediately with the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	485000	A. BUILDING _____ B. WING _____	**09/13/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA VIEW NURSING HOME	**7500 BOLONGO BAY ST THOMAS, VI 00802**

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) accompanying the surveyor who stated the staff needs to check this resident more frequently to make sure he stays covered because he's very restless, he pulls his covers off a lot and he should not be exposed. When the nurse was asked about the condition of the resident's finger and toenails, she explained the cutting of residents fingernails is the responsibility of the Nursing Director and the Doctor is responsible for cutting everyone's toenails. I don't know why they were not done. They should be cut every three months. On 9/9/2013 at 10:00 A.M., during the interview conducted with the Director of Nursing to discuss resident #9 ' s care, the Nursing Director explained the facility maintains a monthly a list of residents who require fingernail and toenail cutting. Residents are scheduled each month, and after the list is completed, it is signed off by the doctor and by the charge nurse or by me. The doctor cuts all of the resident's toenails and I cut the fingernails. The Director of Nurses stated I' m sure that resident (#9) had his nails cut about three months ago. I can check the list, but I know he's on the list for the Doctor for this month. Copies of the fingernail/toenail cutting schedule for the past six months were not immediately available when requested, and when produced, were observed to not have been signed by either the physician or a nurse to indicate each resident on the list had been groomed. Resident #9 was listed on the monthly schedules for November, 2012, February 2013, May 2013, and August 2013. On 9/9/2013 at approximately 5:00 P.M. the Director of nursing informed the surveyor that she had just attempted to cut resident #9's fingernails, but they were too thick and required a larger toenail cutter than the one size available in the facility. The DON stated she would have to find a larger size. A quality of life Assessment Interview was held with residents on 9/10/2013 at 10:30 A.M. 5 of the 5 residents in attendance complained of having to wait for as long as 6 months before their finger and toenails were cut. The Attending Physician, responsible for grooming resident toenails was interviewed 9/11/2013 at approximately 11:00 A.M. and reported to the surveyor that he came in to cut Resident #9s toenails but was unable to do so in the usual manner because the toenails were too mycotic and a special instrument was required. Cross refer F-241
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident without pressure sores, received the necessary care and services to prevent the development of a pressure sore. This was found true for one of 14 residents reviewed. The findings are: During the initial tour, conducted 9/9/2013 at approximately 9:40 P.M. on Unit A, Resident # 9 was observed lying in bed in a supine position. The resident was uncovered, and his feet were exposed. The resident was observed to wear heel pressure relieving booties on both feet. The bootie on his right foot was partially off, not covering the right heel, and the Velcro straps of the bootie were pulled tightly around the anterior longitudinal arch of the resident's foot. The bootie straps were observed to cover an open wound. The nurse accompanying the surveyor was immediately interviewed and stated she thinks the wound developed from the pressure of the bootie straps being pulled too tightly over the resident's foot. The Nurse stated the wound began to develop about three weeks ago. A CNA, identified as a consistent care giver for Resident # 9 was interviewed 9/9/2013 at 9:55 a.m. in the hallway outside of the Resident ' s room. In response to questions about the development of the resident's wound, The CNA stated, the straps on the booties caused the sore because they were being pulled too tight. An interview was held with the Director of Nursing {DON} immediately following the initial tour. The DON described the residents wound as a pressure sore that developed over time and caused by the straps of the bootie being pulled too tightly across the resident's foot. The DON stated they were not treating the wound because there was no drainage. She stated she had not yet in-serviced her staff on the proper application of heel booties to prevent pressure sores from developing, but would do so right away. The DON stated she would have the doctor evaluate the wound to determine what treatment is necessary.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to effectively monitor a resident's nutritional status in the presence of unplanned weight changes. This deficient practice was identified in 1 of 10 residents (Resident #1) reviewed for nutritional concerns. This was evidenced by the following: The resident's [DIAGNOSES REDACTED]. The Clinical records, identified the resident as alert and oriented x 3, and able to make needs known. Resident Assessment Instrument (RAI), dated 8/13/31, indicated the resident's weight as 143 pounds (lbs.) and had experienced no significant weight gain or loss. Review of the physician's orders [REDACTED]. In the Initial Nutritional Assessment, dated 8/6/13, the Registered Dietician documented the resident's weight as 143 lbs., requires partial assist with tray set-up, could feed self, and consuming 75% of meals; weight gain may be due to decrease activity since foot/leg problems. No significant nutritional risk. A review of the resident's monthly weights recorded in the unit's weight book indicates the following: Resident #1's weight was 143 pounds (lbs.) on 08/06/13. On 8/26/13, the resident's weight was recorded as 126 lbs., indicating a 17 lb. weight loss in 20 days. A re-weigh performed on 8/27/13, listed the weight as 126 lbs. There was no documented evidence that the physician was informed of the weight variance of 17 lbs. between 8/6/13 and 8/27/13. The Registered Dietician documented the resident's weight on a Dietary Progress Note dated 9/6/2013 as 125 lbs. and documented that the resident experienced a significant weight loss of 10 lbs. in a 30 day period, and 15 lbs. in a period of 180 days. Although the Registered Dietitian (RD) identified the resident's weight loss as unplanned, there was no documented evidence that the RD evaluated for factors contributing to the resident's weight loss. During an interview conducted on the afternoon of 9/11/13, the Registered Dietitian (RD) acknowledged that the resident experienced a 17 lbs. weight loss. She stated that on 08/27/13, the resident was changed from monthly weights to weekly weights. She further stated that after a discussion with the resident on 09/06/2013, she added Cocoa to the resident's diet. During a Quality of Life Assessment Resident Interview on 09/11/2013 at 6:30 PM resident #1 was asked about whether snacks are provided and she stated they don't give me a sandwich at night, I am a Diabetic and I am not the only one who ' s not receiving a snack at night. There was no documentation in the medical record that any member of the Interdisciplinary Care Team had identified, investigated, or appropriately addressed the resident's weight loss, or identified whether or not the resident's prescribed diet was adequate. This review reveals that the facility's staff waited 2 weeks before addressing the resident's significant weight loss.