STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAUFONT HEALTH AND REHABILITATION CENTER	**200 HIOAKS ROAD RICHMOND, VA 23225**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and staff interview, the facility staff failed to develop and implement a comprehensive care plan for 1 Resident (#107) in a survey sample of 8 Residents. The findings include: For Resident # 107 the facility staff failed to develop and implement a care plan with clearly defined, measurable goals and interventions. Resident #107 a [AGE] year old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #107's most recent MDS dated [DATE] codes the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The Resident is also coded as requiring extensive assistance with all aspects of bathing, dressing, grooming, toileting with physical assistance of 1-2 persons. She is able to eat independently and she propels self in wheelchair as she is unable to walk. On 8/5/2020 during clinical record review it was noted that Resident # 107's care plan read as follows: Focus - Resident is Resistive to care, manipulative behaviors, attention seeking, refuses neb TX, refuses CPA, also hoarding items at bedside and around room, also keeps clutter all around room, increased complaints, false accusations, talks aggressively towards staff, refuses weights, putting items behind her in wheelchair (tissue, clothes, depends), places nebulizer machine in wheelchair and on beds, attempts to ambulate with walker against nursing/ theraphy (sic) advice then falls, refuses to use devices, refuses to use reacher, and rolls out of bed, yells out, hoards batteries from the office, states the vending machine has taken her money to get a refund, hanging legs off the bed, intentionally slides out of the wheelchair so she can get rehab services, noncompliant with wearing a mask, (educated on importance) eats excessively, continues to ask different members for food. Date Initiated - 1/16/20 Created on 2/13/19 Revision 7/23/20. Goal - Clutter Free Environment through next review - Date initiated - 9/16/2019 Created on 2/13/2019 Revision 7/16/2020 Target date 10/12/2020. Interventions - Caregivers provide opportunity for positive interaction, attention, stop and talk with him/her as passing by. (non Pharmacological) Date Initiated: 09/26/2019 Created on 5/20/2019, Revision on 9/26/2019 Encourage to wear mask while out of room. Date Initiated- 7/24/2020 Created on 7/24/2020. Explain all procedures to the resident before starting and allow the resident 10 to adjust to change - Date Initiated: 09/26/2019 Created on 5/20/2019, Revision on 9/26/2019 Offer assistance with organizing items around room, education regarding safety measures r/t clutter - Date Initiated: 09/26/2019 Created on 2/13/2019, Revision on 9/26/2019 PT evaluation for wheelchair positioning - Date initiated 11/4/2019 Created on 11/4/2019 Focus - Resident uses [MEDICAL CONDITION] at night r/t ineffective gas exchange - Date initiated 4/23/20 Created on -4/23/20 Revision on 4/23/20 Goal - The resident will have no s/sx of poor oxygenation absorption through the review date. Date initiated 4/23/20 Created on -4/23/20 Revision on 4/23/20 Interventions - Encourage or assist with ambulation as indicated - Date initiated 4/23/20 Created on -4/23/20. Give Medications as ordered by physician -Date initiated 4/23/20 Created on -4/23/20. Monitor for s/sx of respiratory distress and report to MD as needed - Date initiated 4/23/20 Created on -4/23/20. On 8/7/2020 at approximately 2:30 PM an interview was conducted with Employee B who was asked about the Care Plan. When asked the purpose of the care plan she stated that it was to direct the care of the Resident. When asked if the care plan item listed as having Goal - Clutter free environment through next review appeared accurate she responded no. When asked what was wrong she stated this is just too much in the FOCUS. She said The focus should have been on hoarding/ [DIAGNOSES REDACTED] up room. This focus has everything from hoarding to sliding down in the wheelchair, non compliance with Bi Pap and other behaviors as well. When asked where I would find the information on the BI-Pap usage she pointed out Focus - Resident uses [MEDICAL CONDITION] at night r/t ineffective gas exchange. When asked if it appears correct she stated that it was not and elaborated that it should have included the time it is put on and off who is responsible for cleaning the equipment and any interventions needed for this resident who is documented as being non complaint with Bi-Pap. On 8/7/2020 during the end of day conference the Administrator was made aware of the issues with care plans and no further information was provided.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to review and revise care plans for 2 Residents (#101, & #107) in a survey sample of 8 Residents. The findings included: 1. For Resident #101 the facility staff failed to review and revise care plan to include the PICC (Peripherally Inserted Central Catheter) Line placed for the administration of IV (intravenous) antibiotic therapy for treatment of [REDACTED]. Resident #101, a [AGE] year old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #101's most recent MDS with an ARD of 5/6/2020 coded as a Quarterly assessment coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident is her own responsible party and makes all her own decisions. Resident has a walker, a wheelchair and uses a prosthetic for her right leg (amputated). On 8/5/2020 at approximately 11:15 AM an observation was conducted of Resident #101. There was a sign on the Resident room door stating Contact Precautions, and a bin containing PPE (personal protective equipment) outside the door. RN C was interviewed and she stated Resident 101 (name redacted) is on contact precautions for ESBL (Extended Spectrum Beta Lactamase) in urine. She has chronic UTI's. Upon entering room noted IV pole with empty IV bag hanging not attached to Resident. Resident was sitting in wheelchair watching television. Resident was asked about wounds and she stated that they were getting better. She was asked if there was any pain she stated there was not, and that she is followed by the wound doctor. Resident was asked if she was on IV therapy and she stated that she has a PICC Line again. When asked what the PICC Line was for she replied I have another UTI. On 8/6/2020 the during clinical record review it was discovered that the care plan was not properly revised. The Care Plan read as follows: Focus - PICC/Midline catheter Medication Administration - Date Initiated - 4/13/2020 created 4/13/2020 Revision on: 7/31/2020 Goal - (Left Blank) Interventions - (Left Blank) On 8/6/2020 at approximately at approximately 2:00 PM an interview was conducted with Employee B (corporate nurse) who stated she would check into why the care plan was not revised correctly. Employee B returned at 2:15 PM and had care plan printed in two views, the first view was with all revisions, the second view was the current care plan. Both care plans did not fully address the PICC Line. It shows revision on 7/31/2020 however the Goals and Interventions were blank. She stated that she was unaware of why it was missed. A Review of physician orders [REDACTED]. Antibiotics and Saline and [MEDICATION NAME] Flushes were ordered 7/29/2020 and started on 7/30/2020. On 8/7/2020 during the end of day conference the Administrator was made aware of the care plan omission and no further information was provided. 2. For Resident # 107 the facility staff failed to develop and implement a care plan with measurable review and revise the care plan to update when the Resident

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
	495260	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAUFONT HEALTH AND REHABILITATION CENTER	**200 HIOAKS ROAD RICHMOND, VA 23225**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) began [MEDICAL CONDITION] medications on 10/22/2019 Resident #107 a [AGE] year old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #107 most recent MDS dated [DATE] codes the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The Resident is also coded as requiring extensive assistance with all aspects of bathing, dressing, grooming, toileting with physical assistance of 1-2 persons. She is able to eat independently and she propels self in wheelchair as she is unable to walk. On 8/5/2020 during clinical record review it was noted that Resident # 107 has been taking [MEDICAL CONDITION] medications to include [MEDICATION NAME] and [MEDICATION NAME] since 10/22/2019. At that time a copy of the care plan with all revisions and dates was requested. A review of the Residents care plan revealed no Focus, Goal, or Interventions for [MEDICAL CONDITION] medications. On 8/6/2020 Employee B (corporate nurse) who stated she would check into why the care plan was not revised correctly. Employee B returned with the most recent care plan which had care plan printed for only current care plan. The current care plan read as follows: Focus - The resident uses [MEDICAL CONDITION] medications's r/t behavior management -Date Initiated 6/10/2020 Created on 6/10/2020 Revision on 6/10/2020. Goal - Resident will reduce the use of [MEDICAL CONDITION] medication through the next review date. -Date Initiated 6/10/2020 Created on 6/10/2020 Revision on 6/10/2020. Interventions - Monitor for side effects and effectiveness -Date Initiated 6/10/2020 Created on 6/10/2020 Revision on 6/10/2020. Employee B was asked if the care plan was revised accurately and she stated it was not. She elaborated that it should have been updated to reflect the medication when it was started. It also should show any Interventions for GDR or any non-pharmalogical attempted as well as psych consults. A review of the care plan policy revealed the following excerpts: 6. Computerized care plans will be undated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. On 8/7/2020 during the end of day conference the Administrator was made aware of the issue with care plans and no further information was provided.
F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and facility documentation, the facility staff failed to document medications as ordered by physician for 1 Resident (# 106) in a survey sample of 8 Residents. The findings include: Resident #106, a [AGE] year old female, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #106's Minimum Data Set with an Assessment Reference Date of 06/19/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 meaning intact cognition. Functional status for bed mobility, transfers, toilet use, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Functional limitation in Range of Motion for lower extremity was coded as 2 meaning impairment on both sides. Mobility device was coded as C meaning wheelchair. For the Minimum Data Set with an Assessment Reference Date of 07/10/2020 coded as a discharge assessment, functional status for bed mobility, transfers, toilet use, dressing, and personal hygiene were unchanged and coded as requiring extensive assistance from staff. On 8/6/2020 a review of the clinical record was conducted and it was found among the medications that were ordered by the physician, Carvedilol 6.25 mg (used for blood pressure control) and [MEDICATION NAME] 100 mg (a [MEDICAL CONDITION] medication - used in this Resident for neuropathic pain). A Review of the MAR (Medication Administration Record) Revealed that on 6/13/20 and 6/20/2020 at 6:00 PM there were blank spaces where staff initials should be for [MEDICATION NAME] administration. A review of the MAR for Carvedilol 6.25 mg revealed a blank space on 6/13/2020 and on 6/20/2020 at 6:00 PM where staff initials should be for medication administration. On 8/7/2020 at approximately 1:00 PM an interview was conducted with the Administrator and Employee B and they were shown the MAR and asked what a blank spot means. Employee B stated Even if it was given the assumption must be made that it was not given since there is no documentation. Employee B was asked what a nurse should do if she does not have a medication and she responded First check the stat box and it can be taken from there. Both of these medications should have been in the stat box. On 8/7/2020 a copy of the Stat Box contents was provided and both medications were available in the stat box. On 8/7/2020 during the end of day conference the Administrator was made aware of the issues with medication administration and no further information was provided.