STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENBURNIE REHAB & NURSING CENTER	**1901 LIBBIE AVE RICHMOND, VA 23226**

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 staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to develop a comprehensive care plan to address the identified and assessed risk of falls for one of 14 residents in the survey sample, Resident #2. The findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which the residents was coded as only requiring supervision. For transfers the resident was coded as requiring extensive assistance of two staff members. In Section V - Care Area Assessment, the resident was coded as triggering the care area for falls. An X was documented under that column. The column for Care Planning Decision, documented an X next to falls. Indicating the resident should be care planned for falls. The comprehensive care plan dated 11/13/2020 failed to evidence documentation addressing the identified risk of falls for Resident #2. The care plan dated 11/14/2020, documented in part, Focus: ADL (activities of daily living) - Self-care deficit related to functional [MEDICAL CONDITION] impaired mobility, [MEDICAL CONDITION]. The Goal documented in part, Will not develop complications related to decreased mobility. The Interventions documented occupational therapy and physical therapy evaluation and treatment per physician's orders [REDACTED]. Bed Mobility - assist of two persons. Transfer with Mechanical Lift. Transfer - Assist of two persons. The SBAR (situation, background, assessment and review) dated 12/2/2019 at 11:44 a.m. documented in part, Change in condition noted related to lowered to the floor. The Fall Investigation dated 12/2/2019, documented in part, Equipment - Weight chair and bed were checked. Activity - transferring to weight chair. Resident diagnosis - a check mark was placed next to paralysis (lower extremity). Description of incident - Resident was being transferred from her bed to the weight chair and was lowered to the floor by the CNA (certified nursing assistant). Additional comments - education was provided to the CNA. An interview was conducted with LPN (licensed practical nurse) #2, on 9/28/2020 at 12:35 p.m. When asked who develops and updates the care plans, LPN #2 stated the unit managers, any nurse and MDS. LPN #2 was asked if a resident fall or being lowered to the floor should be on the care plan. LPN #2 stated that if it is something new for the resident it should be put on the care plan. When asked if a resident with [MEDICAL CONDITION] would be considered a fall risk, LPN #2 stated, yes, they have no lower body control and that puts them at risk for falls. The CNA above was no longer employed by the facility and was unavailable for interview. The nurse that documented the 12/12/19 SBAR was no long employed by the facility and was unavailable for interview. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/23/2020 at 2:54 p.m. ASM #2 was asked to review the fall (lowering to the floor) investigation for Resident #2 on 12/2/2019. ASM #2 was asked if the CNA transferred the resident by himself, ASM #2 stated, Yes, he did. When asked if a resident's fall risk and the actual fall should be care planned, ASM #2 stated, yes. ASM #2 was asked to review the resident's care plan. Once reviewed, ASM #2 was asked if Resident #2's care plan addressed her risk for falls or the actual fall on 12/2/2019. ASM #2 stated that there was nothing about falls on the care plan. When asked if there should be, ASM #2 stated, yes there should be, she is at risk. The facility policy, Care Plans, Comprehensive Person-Centered documented in part, A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Receive the services and/or items included in the plan of care .Incorporate risk factors associated with identified problems .The comprehensive, person-centered care plan is developed within seven days of the completed of the required comprehensive assessment (MDS). According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, A written care plan serves as a communication tool among health care team members that helps ensure continuity of care .The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m. No further information was provided prior to exit. (1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435 (2) [DIAGNOSES REDACTED], an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349. (5) [MEDICAL CONDITION] a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, facility document review and in the course of a

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.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) complaint investigation it was determined that the facility staff failed to administer prescribed treatments as ordered by the physician for three of 14 residents in the survey sample, Residents #1, #5, and #12. The findings include: 1. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident #1. Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. Resident #1 no longer resided at the facility and could not be interviewed or observed during the survey. Resident #1's most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 05/21/20, coded Resident #1 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Resident #1 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #1 as having [MEDICAL CONDITION](s) and skin tear(s). The comprehensive care plan for Resident #1 dated 05/11/2020, document in part under Interventions/Tasks, .Administer treatment per physician orders, Date Initiated: 10/14/2019. The care plan further documented, Pain left foot related to wound. Date Initiated: 10/14/2019. A physician order [REDACTED]. The eTAR (electronic treatment administration record) dated 2/1/2020-2/29/2020 for Resident #1 failed to evidence documentation that following treatments were completed on the dates and times listed below. - On 2/3/20, 2/5/20, 2/7/20, 2/10/20, 2/12/20, 2/19/20 and 2/24/20 scheduled for 0900 (9:00 a.m.). Clean foot wound with normal saline, pat dry and reapply new black foam and wound vac, every Monday, Wednesday and Friday. One time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care. Start Date, 01/30/2020 0900 (9:00 a.m.), Hold Date from 02/14/2020 17:13 (5:13 p.m.) to 02/17/2020 2112 (9:12 p.m.). D/C Date- 04/13/2020 1721 (5:21 p.m.). A physician order [REDACTED]. Cover with a bandaid. Apply finger splint to the bottom side of the finger and secure in place by wrapping bandaids around the top of the finger and the base of the finger every day shift for wound care. - On 2/2/20, 2/6/20, 2/8/20, 2/9/20, 2/11/20, 2/14/20, 2/15/20, 2/16/20, 2/18/20, 2/25/20 and 2/27/20 scheduled for 7a-3p (7:00 a.m.-3:00 p.m.). Clean the left hand middle finger wound gently with soap and water. Cover with a bandaid. Apply finger splint to the bottom side of the finger and secure in place by wrapping bandaids around the top of the finger and the base of the finger. Every day shift for wound care- Left middle finger. Start date 01/30/2020 0700 (7:00 a.m.), D/C Date 03/03/2020 1647 (4:47 p.m.). A physician order [REDACTED]. - On 2/2/20, 2/9/20 and 2/16/20 scheduled for 7a-3p. [MEDICATION NAME] border dressing for skin tears on arms and legs, change weekly and as needed. Every day shift every 7 (seven) day(s) for skin tears. Start Date 10/13/2019 0700 (7:00 a.m.), D/C date 03/03/2020 1139 (11:39 a.m.). The progress notes dated 1/1/20 through 2/29/20 for Resident #1 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in February of 2020. On 9/22/20 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used their policies and procedures as their standard of practice. On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the day. LPN #2 stated that they documented on the eTAR after the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, If it is blank, it was not done. LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by the surveyor at that time. On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, If not documented, not done. ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #1. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates. On 9/23/20 at 4:00 p.m., ASM #2 stated that an encrypted email was being sent with follow up progress notes for Resident #1 documenting treatments received. On 9/23/20 at 4:00 p.m., ASM #1, the administrator provided an encrypted email containing progress notes for Resident #1. The document failed to evidence documentation of treatments provided for the additional dates listed above. The facility's policy Wound Care documented in part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data . On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings. On 9/23/20 at 5:18 p.m., ASM #1, the administrator provided an encrypted email containing progress notes for Resident #1 which documented wound care provided on 1/3/2020, 1/9/2020 and 1/10/2020. The document failed to evidence documentation of the treatments provided for the additional dates listed above. No further information was provided prior to exit. Complaint deficiency References: 1. [MEDICAL CONDITIONS]. Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html. 2. Malnutrition- Food provides the energy and nutrients you need to be healthy. If you don't get enough nutrients -- including proteins, carbohydrates, fats, vitamins, and minerals - you may suffer from malnutrition. This information was obtained from the website: https://medlineplus.gov/malnutrition.html 3. Diabetes mellitus a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm. 4. Foot ulcer if you have diabetes, your blood glucose, or blood sugar, levels are too high. Over time, this can damage your nerves or blood vessels. Nerve damage from diabetes can cause you to lose feeling in your feet. You may not feel a cut, a blister or a sore. Foot injuries such as these can cause ulcers and infections. Serious cases may even lead to amputation. Damage to the blood vessels can also mean that your feet do not get enough blood and oxygen. It is harder for your foot to heal, if you do get a sore or infection. This information was obtained from the website: https://medlineplus.gov/diabeticfoot.html 5. Pressure ulcer are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/ 7.htm. 2. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident # 5. Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Resident #5's most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 09/07/2020, coded Resident #5 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Resident #5 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #5 as having two Stage 3- Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling. Section M further documented Resident #5 having one Stage 4-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Section M also documented Resident #5 having surgical wound(s). On 9/22/20 at approximately 9:30 a.m., an interview was conducted with Resident #5. A brief cognition interview revealed Resident #5 oriented to person and place. Resident #5 stated that the staff provide treatment to them almost every day. Resident #5 stated that they did not know how often they were supposed to get their treatments. Resident #5 stated that there were days that it took them a while to get to the treatments because they were so busy. The comprehensive care plan for Resident #5 dated 9/23/20, documented in part, Has/At risk for further alteration in skin integrity related to impaired mobility, hx (history) pressure ulcer, [MEDICAL CONDITION] (diabetic nerve damage) .Because of current hx and dx (diagnosis) resident is at high risk for skin breakdown and for further breakdown of current areas. Hx of scrotal (scrotum) area, hx sacral (lower back between the hipbones) area . Date Initiated: 03/18/2016, Revision on 04/22/2019. Under Interventions/Tasks, it documented in part, treatment as ordered. Date Initiated: 09/29/2016, Revision on 11/28/2017. The care plan for Resident #5 also documented, Resistive/noncompliant with treatment/care (wound care orders) related to believe that treatment isn't needed/working; sits up for long periods of time. Inserts fingers into rectum causing trauma, sits on the bed pan for long periods of time. Date Initiated: 12/01/2019, Revision on 01/23/2020. Under

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Interventions/Tasks it documented in part, Allow for Flexibility in ADL (activities of daily living) routine to accommodate mood, preferences and customary routine, Date Initiated: 01/23/2020. It also documented, If resisting care, leave (if safe to do so) and return later, Date Initiated: 01/23/2020, and Provide education about risks of not complying with therapeutic regimen, Date Initiated: 01/23/2020. Under Interventions/Tasks, it documented in part, Administer treatment per physician orders. Date Initiated: 12/10/2019. Review of the physicians orders revealed the following an order dated 8/31/20 which documented, Greers Goo (medicated barrier cream), apply to testicles and groin area Q (every) shift for rash. It further documented an order dated 8/31/20 that documented, NYAMYC Pow (powder) 0 (antifungal medicated powder) Apply to groin topically every day and evening shift for rash. The eTAR (electronic treatment administration record) dated 1/1/2020-1/31/2020 and 2/1/2020-2/29/2020 for Resident #5 failed to evidence documentation that following treatments were completed on the dates and times listed below: - On 2/15/20 scheduled for 7a-3p, and on 1/22/20 and 2/3/20 scheduled for 3p-11. On 1/30/20 and 2/17/20 scheduled for 11p-7 (between 11:00 p.m. and 7:00 a.m.). Greers Goo, apply to testicles and groin area Q (every) shift for rash. Start date: 10/03/2019 1500 (3:00 p.m.). D/C Date: 06/02/2020 1349 (1:49 p.m.). - On 2/15/20 scheduled for 7a-3p, and on 1/22/20 and 2/3/20 scheduled for 3p-11 (between 3:00 p.m. and 11:00 p.m.). NYAMYC Pow 0, Apply to groin topically every day and evening shift for rash. Start Date: 09/25/2019 0700 (7:00 a.m.). D/C Date: 03/03/2020 1531 (3:31 p.m.). The progress notes dated 1/1/20 through 2/29/20 for Resident #5 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in January and February of 2020. On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the shift. LPN #2 stated that they documented on the eTAR after the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, If it is blank, it was not done. LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by the surveyor at that time. On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, If not documented, not done. ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #5. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates. On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings. No further information was provided prior to exit. Complaint deficiency References: 1. [DIAGNOSES REDACTED] [DIAGNOSES REDACTED] is the medical term for inflammation in a bone. It's usually caused by a bacterial infection. It often affects the long bones of the arms and legs, but can happen in any bone. This information was obtained from the website: https://kidshealth.org/en/parents/osteo[DIAGNOSES REDACTED].html 2. Pressure ulcer A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/ 0.htm. 3. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm. 3. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident #12. Resident #12 was admitted to the facility with [DIAGNOSES REDACTED]. Resident #12 no longer resided at the facility and could not be interviewed or observed during the survey. Resident #12's most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 01/02/20, coded Resident #12 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident #12 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #1 as having [MEDICAL CONDITION](s). The comprehensive care plan for Resident #12 dated 02/12/2020 documented in part, Actual skin breakdown related to right heel, Date Initiated: 12/27/2019, Revision on: 02/12/2020. Under Interventions/Tasks it documented in part, Administer treatment per physician orders, Date Initiated: 12/27/2019, Revision on: 02/12/2020. A physician's note dated 1/1/2020 at 16:21 (4:21p.m.) documented in part, . Left [MEDICAL CONDITION] S/P debridement 12/19. Review of the physician's orders [REDACTED]. Primary dressing: apply santyl (used to remove dead tissue) and alginate calcium. Secondary dressing: Foam silicone. Apply HeelMedix (cushioned boot to reduce pressure on heel) when in bed. Patient may ambulate with gripper socks. - 1/20/2020, Apply zinc paste (barrier cream) to buttocks for preventative. Every evening shift for preventative. The eTAR (electronic treatment administration record) dated 1/1/2020-1/31/2020 and 2/1/2020-2/29/2020 for Resident #12 failed to evidence documentation that following treatments were completed on the dates and times listed below: - On 1/13/20, 1/22/20, 1/25/20, 2/2/20, and 2/6/20 scheduled for 7a-3p. Clean left foot/heel wounds with soap and water. Primary dressing: apply santyl (used to remove dead tissue) and alginate calcium. Secondary dressing: Foam silicone. Apply HeelMedix (cushioned boot to reduce pressure on heel) when in bed. Patient may ambulate with gripper socks. Do not apply shoe to the left foot. Every day shift for wound care. Start Date: 01/10/2020 0700 (7:00 a.m.), D/C Date: 08/26/2020 1452 (2:52 p.m.). - On 1/11/20, 1/23/20, 1/27/20, 2/1/20, 2/3/20 and 2/6/20 scheduled for 3p-11 (between 3:00 p.m. and 11:00 p.m.). Apply zinc paste (barrier cream) to buttocks for preventative. Every evening shift for preventative. Start Date: 01/10/2020 1500 (3:00 p.m.), D/C (discontinue) Date- 08/26/2020 1452 (2:52 p.m.). The progress notes dated 1/1/20 through 2/29/20 for Resident #12 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in January and February of 2020. On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, If not documented, not done. ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #12. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates. On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings. No further information was provided prior to exit. Complaint Deficiency References: 1. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm. 2. End-stage kidney disease The last stage of [MEDICAL CONDITION]. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/ 0.htm. 3. [MEDICAL CONDITION] Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, facility document review and in the course of a complaint investigation it was determined facility staff failed to provide treatments as ordered by the physician for the care of a pressure ulcer for one of 14 residents in the survey sample, Resident #5. The findings include: Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Resident #5's most recent MDS (minimum data set), a five day assessment with an ARD (assessment reference date) of 09/07/2020, coded Resident #5 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Resident #5 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #5 as having two Stage 3- Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling. Section M further documented Resident #5 having one Stage 4-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining

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	495391	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) and tunneling. On 9/22/20 at approximately 9:30 a.m., an interview was conducted with Resident #5. A brief cognition interview revealed Resident #5 oriented to person and place. Resident #5 stated that the staff provide treatment to them almost every day. Resident #5 stated that they did not know how often they were supposed to get their treatments. Resident #5 stated that there were days that it took them a while to get to the treatments because they were so busy. The comprehensive care plan for Resident #5 documented in part, Actual skin breakdown including stage 4 (four) wound to right heel and sacrum, DTI (deep tissue injury) to left heel, right great toe diabetic ulcer and moisture associated ulceration noted under and around bilateral sides of scrotum. Date Initiated 12/10/2019. Revision on: 08/17/2020. Under Interventions/Tasks, it documented in part, Administer treatment per physician orders. Date Initiated: 12/10/2019. The physician's orders [REDACTED]. The physician's orders [REDACTED].#5 documented in part, 9/1/2020 14:04 (2:04 p.m.) .Skin Note .Right heel- wound resolved: right above the knee amputation . The eTAR (electronic treatment administration record) dated 1/1/2020-1/31/2020 and 2/1/2020-2/29/2020 for Resident #5 failed to evidence documentation that following treatments were completed for the pressure ulcer (sacrum) on the dates and times listed below. On 1/14/20, 1/22/20, 1/23/20, 1/29/20, 2/15/20 and 2/25/20 scheduled for 7a-3p (between 7:00 a.m. and 3:00 p.m.). Clean the sacral wound with soap and water daily. Pack collagen (protein) into the wound and cover with calcium alginate (absorbent dressing) and foam. Change dressing daily and when soiled. Every day shift for wound care. Start Date: 01/14/2020 0700 (7:00 a.m.), D/C (discontinue) 03/26/2020 1338 (1:38 p.m.). On 1/22/20, 1/23/20, 1/29/20 and 2/15/20 scheduled for 7a-3p. Clean the right heel wound with soap and water daily. Apply calcium alginate to the wound bed then a gauze dressing. Change dressing daily. Apply HeelMedix boots (padded footwear to relieve pressure to heels) to bil (bilateral) feet as preventative. Every day shift for wound care, Start Date 01/14/2020 0700 (7:00 a.m.). D/C Date- 03/26/2020 1336 (1:36 p.m.). The progress notes dated 1/1/20 through 2/29/20 for Resident #5 failed to evidence documentation for the incomplete pressure ulcer treatment dates documented above on the eTAR in January and February of 2020. On 9/22/20 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used their policies and procedures as their standard of practice. On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the day. LPN #2 stated that they documented on the eTAR after the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, If it is blank, it was not done. LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by the surveyor at that time. On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, If not documented, not done. ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #5. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates. The facility's policy Wound Care documented in part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data . On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings. No further information was provided prior to exit. Complaint deficiency References: 1. [DIAGNOSES REDACTED] [DIAGNOSES REDACTED] is the medical term for inflammation in a bone. It's usually caused by a bacterial infection. It often affects the long bones of the arms and legs, but can happen in any bone. This information was obtained from the website: https://kidshealth.org/en/parents/osteo[DIAGNOSES REDACTED].html 2. Pressure ulcer A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/ 0.htm. 3. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to ensure a proper transfer per the plan of care to prevent an avoidable accidents for one of 14 residents in the survey sample Resident #2. On 12/2/19, Resident #2 was transferred from her bed to the weight chair by a CNA (certified nursing assistant) and was subsequently lowered to the floor. The CNA failed to ensure Resident #2 was transferred with the assistance two staff members as assessed. The findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which was only required supervision. For transfers the resident was coded as requiring extensive assistance of two staff members. In Section V - Care Area Assessment, the resident was coded as triggering the care area for falls. An X was placed under that column. The column for Care Planning Decision, documented an X next to falls. Indicating the resident should be care planned for falls. The SBAR (situation, background, assessment and review) dated 12/2/2019 at 11:44 a.m. documented in part, Change in condition noted related to lowered to the floor. The Fall Investigation dated 12/2/2019, documented in part, Equipment - Weight chair and bed were checked. Activity - transferring to weight chair. Resident diagnosis - a check mark was placed next to paralysis (lower extremity). Description of incident - Resident was being transferred from her bed to the weight chair and was lowered to the floor by the CNA (certified nursing assistant). Additional comments - education was provided to the CNA. The Employee Education Attendance Record dated 12/2/2019, documented in part, At the completion of this training session the participant will: appropriate transfer techniques, CNA Kardex, Appropriate body mechanics and requesting assistance as needed. The comprehensive care plan dated 11/13/2020 failed to evidence documentation tor the assessed risk of falls for Resident #2. The care plan dated 11/14/2020, documented in part, Focus: ADL (activities of daily living) - Self-care deficit related to functional [MEDICAL CONDITION], impaired mobility, [MEDICAL CONDITION]. The Goal documented in part, Will not develop complications related to decreased mobility. The Interventions documented occupational therapy and physical therapy evaluation and treatment per physician's orders [REDACTED]. Bed Mobility - assist of two persons. Transfer with Mechanical Lift. Transfer - Assist of two persons. The Resident Evaluation dated, 11/13/2019, documented in part, Fall Risk Predictive Factors Assessment - A. Mental status - alert, oriented, reliable safety awareness. B. Ambulatory Elimination Status - Impaired mobility. Vision Status - adequate. Orthostatic Blood Pressure - unable to determine. Falls History - no falls in past 3 months. medications: [REDACTED]. Predisposing Diseases/Conditions - Respond below back on the following predisposing conditions: Hypertension, [MEDICAL CONDITIONS] (stroke) [MEDICAL CONDITION], Loss of Limb, [MEDICAL CONDITION], arthritis, [MEDICAL CONDITION], fractures, dementia, [MEDICAL CONDITION], wandering, anger. None present. (Of note, the resident had the [DIAGNOSES REDACTED]. There

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) was no documentation of what the score of 5 indicated on the form. The CNA above was no longer employed by the facility and was unavailable for interview. The nurse that documented the SBAR was no long employed by the facility and was unavailable for interview. An interview was conducted with CNA #5, on 9/23/2020 at 12:20 p.m. When asked how she knows what kind of transfer assistance a resident requires, CNA #5 stated that it's on the kardex in POC (point of care electronic record). When asked if it documents a mechanical lift, can you transfer the person without the lift, CNA #5 stated, No, you have to use the lift and the lift requires you have two persons at all times. An interview was conducted with LPN (licensed practical nurse) #2 on 9/23/2020 at 12:35 p.m. When asked how a staff know what kind of assistance a resident requires for transfers, LPN #2 stated it's in the care plan and on the kardex. When asked if the staff could transfer a resident without a lift, if the Kardex documents to use a mechanical lift, LPN #2 stated if it says mechanical lift, then that's the only safe way to transfer the resident. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/23/2020 at 2:54. When asked if the CNA attempted to transfer Resident #2 on 12/2/2019 by himself, ASM #2 stated, Yes, he did. The Resident Evaluation dated 11/13/2019 and the Fall Risk Evaluation dated 12/2/2019 were reviewed with ASM #2. When asked what the Resident Evaluation meant in relation to falls, ASM #2 stated the resident would be at risk based on the assessment. When asked what a 5 on the Fall Risk Evaluation indicated, ASM #2 stated that the resident was at risk for falls. The facility policy, Safe Lifting and Movement of Residents documented in part, In order to protect the safety and well-boing of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals ad decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m. No further information was provided prior to exit. (1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435 (2) [DIAGNOSES REDACTED], an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet.) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349. (5) [MEDICAL CONDITION] a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to document the wound measurements of a pressure injury, in the clinical record, for one of 14 residents in the survey sample, Resident #2. The findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which was only required supervision. For transfers the resident was coded as requiring extensive assistance of two staff members. In Section M - Skin Conditions, the resident was coded as having a stage IV (4) pressure injury. The Resident Evaluation dated 11/13/2019, documented the resident had a open area on the sacrum that measured 4x4 (centimeters(cm) - length by width), 2.5 (cm) deep, pinkish with yellow slough intermittently, edges defined, some tunneling. The wound care physician notes dated 11/14/2019, documented the residents pressure injury wound, on the sacrum, as being 8x6x2 cm (length by width by depth). The wound care physician notes dated 11/21/2019, documented the residents pressure injury wound, on the sacrum, as being 6x5.5x1.9 cm. Review of the clinical record failed to evidence of any wound measurements after 11/21/2019. A request was made for any wound tracking documents from 11/21/2019 through 12/12/2019 of ASM (administrative staff member) #1, the administrator, on 9/23/2020 at 1:59 p.m. On 9/23/2020 at 3:47 p.m. the following documents were presented. Weekly Wound Management Tracking Tool dated 11/27/2019, 12/5/2019 and 12/12/2019: - The Weekly Wound Management Tracking Tool dated 11/27/2019 documented Resident #2's wound measurements as 6 x 5.5 x 3.8 cm. - The Weekly Wound Management Tracking Tool dated 12/5/2019 documented Resident #2's wound measurements as 6 x 5.5 x 3.8 cm. - The Weekly Wound Management Tracking Tool dated 12/12/2019 documented Resident #2's wound measurements as 6 x 6.3 x 3.8 cm. None of these measurements were in the clinical record. ASM #1, the administrator, informed this surveyor on 9/23/2020 at 3:47 p.m. that it was correct, the above measurements were not in the clinical record. When asked if they should be, ASM #1 stated, Yes, Ma'am. The facility policy, Charting and Documentation documented in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation of procedures and treatments will include care-specific details, including: the date and time the procedures/treatment was provided. The name and title of the individual(s) who provided care. The assessment data and/or any unusual findings obtained during the procedure/treatment. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m. No further information was provided prior to exit. (1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435. (2) [DIAGNOSES REDACTED], an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet.) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349. (5) [MEDICAL CONDITION] a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55