STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495403	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEWOOD MANOR	1900 LAUDERDALE DRIVE RICHMOND, VA 23238

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility staff failed to ensure the accuracy of assessments for 1 Resident (#3) in a survey sample of 4 Residents. The findings included: For Resident #3 the facility staff failed to accurately complete section of the MDS pertaining to pain medication and psychiatric illness. Resident #3 was admitted to the facility on originally on 3/06/14, with readmission after hospitalization on [DATE]. The [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/30/30 coded Resident #3 with a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #3 requiring extensive assistance for Activities of Daily Living care. On 8/26/20 at approximately 10:00 AM a review of the clinical record revealed that the most recent MDS assessment with an ARD date of 7/30/20. Section I - Psychiatric / Mood Disorder- boxes not checked for - Anxiety Disorder or Depression. However, both are [DIAGNOSES REDACTED]. was not checked. However, the clinical record revealed the Resident has been to the ER for a fractured humeral head (shoulder) on 7/25/20 and received PRN [MEDICATION NAME] and [MEDICATION NAME] on 7/25/20 and 7/26/20. The Administrator was made aware of the concerns at the end of day meeting 8/27/20 and no further information was provided.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, facility documentation and in the course of a complaint investigation, the facility staff failed to review and revise the care plan for 1 Resident in a survey sample of 4 Residents. The findings included: For Resident #3 the facility staff failed to review and revise the care plan with measurable goals and interventions with each fall the Resident had. Resident #3 was admitted to the facility on originally on 3/06/14, with readmission after hospitalization on [DATE]. The [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/30/30 coded Resident #3 with a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #3 requiring extensive assistance for Activities of Daily Living care. On 8/26/20, during clinical record review, it was noted that the resident had sustained 19 falls from 1/1/20 through 8/26/20 the dates are as follows: 1/8/20 - 1/24/20 - 1-29-20 - 2/14/20 - 3/29/20 - 4/6/20 - 4/7/20 (at 10:00 AM) - 4-7-20 (at 11:30 AM) - 4/15/20 - 4/28/20 - 5/10/20 - 6/8/20 - 6/11/20 - 6/13/20 - 6/24/20 - 7/7/20 - 7/24/20 - 8-3-20 - 8/21/20 On 8/26/20 a review of the care plan revealed that measurable goals and interventions were not put in place with each fall. The care plan also reflects that sometimes interventions were dated as beginning before the fall and sometimes not until a week after the fall. Excerpts read as follows: (A) fall on 1/8/20 Educate (family member) not to assist the resident until nurse has assessed resident and environmental causative factors. Start - 1/14/20 NOTE: This intervention will not aid in prevention of falls and it is not measurable. (A) fall on 5/10/20 continue all of the above as the patient is non-compliant. Start 4/3/20 NOTE: This was dated 2 months prior to fall indicating this intervention was in place prior to 5/10/20. (A) fall on 7/7/20 continue all of the above as the patient is non-compliant. Re-Educate to use the call bell when she needs to get up Start date 7/7/20 NOTE: Resident #3 has dementia and according to the Medical Director in an interview on 8/27/ at 11:57 The dementia prevents her from remembering she needs to ask for assistance, so education is not effective. The falls on 3/29/20, 4/6/20, 4/7/20 (both falls), 4/15/20, 4/28/20, 6/8/20, 6/11/20, 6/13/20, 6/24/20 and 8/21/20 were not mentioned in the care plan nor were interventions put in place. On 8/26/20 a review of the care plan policy was conducted and excerpts read as follows: Page 4 of 4 Section Number: 8 15) the care Planning / Interdisciplinary Team is responsible for the review and updating of care plans: a) When requested by the resident / resident representative b) When there has been a significant change in the resident's condition c) When the desired outcome is NOT met On 8/26/20 at 1:30 PM an interview was conducted with the ADON who stated that the Resident was on the Falling Star Program. When asked how would one know that, she stated, It should be on her care plan. When asked who is responsible for updating the care plans she said We all are, that is nurses all have access and are supposed to do it with each fall and change in condition. All disciplines can add to the care plan it is not one person's responsibility. However, a review of the care plan revealed that The Falling Star Program was not listed as an intervention her plan of care. A Review of the falling star program read: Criteria - Any Resident that has fallen at least 2 times in 7 days or 3 or more times in 30 days will be placed on the Falling Star Program. The Care Plan will be updated to include the Falling Star Program as a fall prevention intervention. On 8/26/20 at approximately 2:00 PM an interview was conducted with the DON who stated We recently started another intervention of placing the resident in her doorway with her overbed table and some magazine in front of her to occupy her and to ensure that she is easily visible from the hallway and nurses station. The DON also stated that this intervention would be more effective once she gets her eyeglasses replaced. A review of the care plan revealed the intervention of placing the resident in her doorway with her overbed table and some magazine in front of her was not added to the care plan, however the DON provided a copy of the incident report excerpts that read: 8/24/20 at 4:27 PM - (DON name redacted) Resident fall discussed with ID team and the following intervention was developed in an effort to prevent future falls. RR notified of fall. Will continue to monitor resident and intervention for appropriateness. Intervention: Seat resident at doorway threshold for better observation. Table in front of resident with magazines for pleasure. On 8/27/20 at approximately 10:30 AM an interview was conducted with LPN B who was asked the procedure or policy when a Resident falls. LPN B stated When a Resident falls we assess the resident for injuries, we notify the MD and RP, we do a fall investigation sheet and pain assessment, and we update the care plan and document in the nurses notes. When asked who was responsible for updating the care plan she stated All the nurses really. We all have access to it and when you do the fall investigation you have a section where you put in an intervention for the care plan. On 8/27/20 at approximately 11:00 AM an interview was conducted with LPN A who stated After someone falls you have to assess them for injury, then do a pain assessment, if it was unwitnessed start neuro checks, do a fall investigation, notify the MD and RP and update the care plan and put in an intervention and document in the nurses notes. On 8/27/20 during the end of day conference the Administrator was made aware of the concerns 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 observation, interview, clinical record review, facility documentation and in the course of a complaint

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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F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) investigation, the facility staff failed to maintain accurate clinical record. The findings included: For Resident #3, the facility staff failed to accurately document the injuries sustained by Resident #3 in a fall on 5/11/20 and the subsequent follow up as it pertains to reason for Antibiotic use and [DIAGNOSES REDACTED].#3 was admitted to the facility on originally on 3/06/14, with readmission after hospitalization on [DATE]. The [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of coded Resident #3 with a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #3 requiring extensive assistance for Activities of Daily Living care. On 8/26/20 a review of the clinical record revealed that Resident #3 had multiple (20) falls in the time period from 1/1/20 to 8/27/20. A review of the physician notes regarding the falls revealed several inconsistencies. Excerpts are as follows: Follow - Up Note Date of Service - 5/11/20 (Resident name redacted) Reason for Visit: 1. fall with right wrist fracture 2. Low grade fever The patient is a long term care patient at (facility name redacted) with history of advanced dementia, reactive airway disease, hypertension who was recently sent to the emergency room last night after a fall. She was diagnosed with [REDACTED]. She has also been running a low grade fever. She has been started on _____ (blank space left in note) at the facility. She does have history of urinary tract infection [MEDICAL CONDITION] in the past. She is not complaining of any urinary symptoms although she has dementia. She is not a reliable historian. She has no cough, no shortness of breath, no wheezing at present. Her blood pressure remains under control and pain is well controlled on current pain medications. She had x-rays done in the hospital which showed a dorsal displaced radial fracture fragment and also has a mildly displaced ulnar fracture. Pain is under control. CT was negative of the hips and x ray also negative. A review of the Vital signs record for this resident revealed she did not have a fever until after her return from hospital. The Resident temperature was recorded in the emergency room record as 98.4 on 5/10/20. ACUTE VISIT Date of service 5/14/20 (Resident name redacted) Reason for Visit: 1. Urinary tract infection 2. Recent right hip (sic) fracture She was sent to the emergency room . She was treated in the hospital and later readmitted here. She has been having some fever before she fell . She does have a history of urinary tract infection [MEDICAL CONDITION] in the past and usually leads to her falls. Urine was ordered which has come back positive, although the final culture is not back yet, but does have positive [MEDICATION NAME] and leukocyte esterase. She is on Keflex for her open fracture. She continues to have fever, today was 100.1. She has no cough, no shortness of breath, no phlegm, and no GI symptoms. She does not give any [MEDICAL CONDITION] symptoms but has dementia and is not a reliable historian. Plan: 1. Discontinue Keflex. Start [MEDICATION NAME] 500 mg daily for 1 week. Follow - Up Note Date of service 5/18/20 (Resident name redacted) Reason for Visit: Follow up on fever and recent fall with right wrist fracture. Recently, she had a fall and suffered a right wrist fracture. When she came back from the hospital she was running a fever. We did order a urine on her as she has a history of urinary tract infection [MEDICAL CONDITION] in the past that she gets when she is confused. (Sic) She is currently not on any antibiotics. Her pain is well controlled on current pain medication. She has remained afebrile over the last 48 hours and currently has no symptoms, no cough, no shortness of breath, no gastrointestinal (GI) or [MEDICAL CONDITION] symptoms. Assessment: 1. Fever resolved. Urine is negative. No need to start antibiotics. 2. Fall with right wrist fracture. Pain is under control. Continue PT and OT. 3. Advanced dementia 4. [MEDICAL CONDITION] Remains high risk for falls. Monitor closely for that. Electronically signed by (Medical Director Name redacted) On 8/26/20 at approximately 10:56 AM an interview was conducted with the ADON, DON, Administrator and the Medical Director. In the physician note dated 5/11/20 it stated She has also been running a low grade fever. She has been started on _____ (blank space left in note) at the facility. When asked if it is usual practice to leave a blank space in a note he stated No. When asked if the Resident was started on antibiotics at the facility or at the hospital. He stated She was started on Keflex at the hospital and was changed to [MEDICATION NAME] at the facility on 5/14/20 for fever and suspected UTI. In physician note dated 5/14/20 he states - Reason for Visit: 1. Urinary tract infection 2. Recent right hip (sic) fracture. Also, in the note on 5/14/20 it states She has been having some fever before she fell . She does have a history of urinary tract infection [MEDICAL CONDITION] in the past and usually leads to her falls. Urine was ordered which has come back positive, although the final culture is not back yet, but does have positive [MEDICATION NAME] and leukocyte esterase. She is on Keflex for her open fracture. When asked if this was accurate he stated No it was right wrist fracture not right hip. When asked if the Resident had an open fracture as stated in his note on 5/14/20 he stated that it was an error the Resident did not have an open fracture. The note dated 5/18/20 states When she came back from the hospital she was running a fever. We did order a urine on her as she has a history of urinary tract infection [MEDICAL CONDITION] in the past that she gets when she is confused. (Sic) She is currently not on any antibiotics. When asked if the Resident was still on antibiotics on 5/18/20 he said Yes the antibiotics were changed from Keflex to [MEDICATION NAME] but she did take them for a week. On 8/27/20 at 11:00 AM the facility presented the Addendums to the Physician notes from 5/14/20 and 5/18/20 they read: Date of Service 5/14/20 Addendum The patient was to the hospital after a fall causing a right wrist fracture. In the hospital she was stared on Keflex for a possible urinary tract infection [MEDICAL CONDITION] not for open fracture of her wrist. She actually had closed fracture of right wrist. Electronically signed (Medical Director Name Redacted) 8/27/20 at 7:50 AM Date of Service 5/18/20 Addendum The patient was being treated for [REDACTED]. I had started her on [MEDICATION NAME] on 8/14/20 for possible UTI. So on 5/18/20 she was still on [MEDICATION NAME]. Although her urine culture had come back negative but because she had a fever and was increasingly confused there was a high suspicion for some kind of infection going on. That's why, I let her finish the antibiotic to complete the course for one week to finish on 5/21/20. Electronically signed (Medical Director Name Redacted) 8/27/20 at 7:49 AM On 8/27/20 the Administrator was made aware of the concerns with the documentation and no further information was provided