STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENCY HEALTH AND REHABILITATION CENTER	**112 N CONSTITUTION DR GRAFTON, VA 23692**

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure 1 resident (#1) was free from neglect in a survey sample of 3 residents. The findings included: For Resident #1 the facility neglected to obtain a STAT appointment (as ordered). Resident #1, a [AGE] year-old woman was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as Z- none of the above indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. On 10/30/20 clinical record review was revealed Resident #1 was admitted to the facility after having amputation of the fourth toe on the left foot, She was ordered to receive IV as well as oral antibiotics, physical therapy and wound care while at the facility. She was admitted with a Groshong catheter (implanted central line port to administer antibiotics). A record review reveled the following: 8/25/20 at 12:00 AM : Since patient has been admitted she has not received a dose of [MEDICATION NAME]. Initially she was started on the wrong antibiotic, [MEDICATION NAME], and received at least three doses of that. Her right Groshong catheter lost its lumen and a peripheral IV was placed last evening. Now this is currently not functioning or flushable. Skin:Where the fourth toe was previously located, ulcer with white base, no drainage, non tender, no [DIAGNOSES REDACTED], no odor. Plan:STAT vascular surgeon consult (doctors name redacted) to fix Groshong Cath so she can receive antibiotics. Note: STAT refers to immediate 8/26/20 at 4:01 PM (Doctors name redacted) Office called concerning having residence Groshong catheter replaced due to it being removed. Left a voicemail with (name redacted) surgical scheduler at the (doctors name redacted). Office waiting awaiting a return phone call. PA (physician assistant) notified (LPN name redacted). 8/27/20 at 12:08 PM call placed to (Doctors name redacted) office to schedule central line (Groshong Cath) 8/21/20 insertion message left for (Name redacted) surgical coordinator resident made aware. (LPN name redacted). On 10/1/20 2:12 PM an interview was conducted with the DON who was asked about the order on 8/25/20 for STAT appointment with surgeon to place the central line she stated we could not get in touch so we called the PICC team and they put in a PICC LINE in her upper right arm on the night of 8/27/20 and she got her first dose of [MEDICATION NAME] on the morning of 8/28/20. Excerpt from the facility Abuse/Neglect Policy read: Policy #703 page 93 Neglect means a repeated or willful failure to provide timely and consistent services treatment or care to a patient which are necessary to obtain or maintain the patient's health safety or comfort On 10/1/20 during the end of day meeting the Administrator was made aware of these concerns and no further information was provided.
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 interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to develop and implement a comprehensive care plan that includes measurable objectives and is Resident centered for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1 the facility failed to include care areas for wound care, pain, fluid restriction, non weight bearing status and updated the care plan after the Resident was discharged to the hospital. Resident #1, a [AGE] year-old woman was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as Z- none of the above indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. On 10/1/20 a review of the clinical record revealed the facility failed to address all aspects of care on her care plan. Care area focus of Pain was not addressed in the care plan until it was entered on 9/8/20 (5 days after discharge), in spite of her increasing pain requiring her to go from a PRN every 4 hours to a routine every 4 hours dose of [MEDICATION NAME] 2 mg (Opioid pain medicine). Care area focus Resident has potential for dehydration or potential fluid deficit due to infection was entered on 9/8/20 (5 days after discharge). Care area focus The Resident has bladder incontinence r/t impaired mobility was entered on 9/8/20 (5 days after discharge). However, the resident is anuric (does not urinate) related to end stage [MEDICAL CONDITION] and [MEDICAL TREATMENT] per hospital discharge and facility admission assessment. Under the focusResident has limited physical mobility related to weakness created 8/21/20 the goal states Resident will demonstrate appropriate use of adaptive devices to increase mobility throughout the review date dated 9/8/20 Revision 9/8/20 target date 11/19/20 Intervention locomotion the resident is able with limited assistance (left incomplete) created 9/8/20 revision 9/8/20 (note this resident is coded as not using a wheelchair, crutches, cane or walker per MDS) On 10/1/20 at 3:00 PM, the DON was asked to provide notes about the focus area Resident is resistant to care R/T refuses therapy and medications. Noncompliant with fluid restriction created on 9/2/20 revision 9/3/20. No notes related to refusal of, or resistance to care, medications or treatments were provided. However, the DON provided notes as follows; 9/3/20 at 11:41 PM patient noted to be noncompliant with diabetic diet and fluid restriction 8/31/20 at 4:05 AM patient is requesting chips and other snacks from nurse and CNA this shift. She has been educated that her blood sugar was above 400 before bed and she is allowed to have sugar free pudding if she would like a snack. Patient declined sugar-free snacks and asked what did chips have to do with my blood sugar being high?. More education provided to patient regarding healthy snack choices On 0/1/20 at approximately 11:00 AM, during an interview, LPN B stated, All nurses have access to the care plan we can all update it. On 10/1/20 approximately 3:00 PM the Administrator was asked about the care plans being updated after the Resident had been discharged he stated that the MDS person was off and the care plan got updated when she returned the Tuesday after labor day. On 10/1/20 during end of day meeting the Administrator was made aware of the concerns and no further information was provided.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to provide services as directed by the care plan that meet with professional standards of care for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1 the facility failed to: A) properly care and maintain the Groshong Central Line Catheter and B) failed to correctly document progression of wound. Resident #1, a [AGE] year-old woman was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. diabetes type two. [MEDICAL CONDITION] lower limb,[MEDICAL CONDITION]. [MEDICAL CONDITION]. surgical removal of fourth toe on left foot. end stage [MEDICAL CONDITIONS], hypertension, and was a [MEDICAL TREATMENT] patient. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as Z- none of the above indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. A) On 9/30/20 a review of the clinical record revealed that Resident #1 had orders that read: Central line flush-10 ml NS (normal saline) flush and follow with 5 ml 10 units/ml [MEDICATION NAME] one time per day for maintenance start date 8/23/20 Note: The resident was admitted to the facility on [DATE] but the orders were not put in for flush until 8/23/20. 8/24/20 8:02 PM - Resident right chest Cath is inaccessible. No lumen present. No S/S of infection at the site. Order received have Cath changed. Mobile services state they cannot replace a tunneled chest cath. Resident sent non-emergent to (hospital name redacted) for chest Catheter placement. Message left for LTC on-call. Resident informed older sister of her condition. (LPN #1 name redacted). 8/24/20 at 8:23 PM orders administration note [MEDICATION NAME] HCl solution 1 g/50 ml administration PICC line inaccessible resident sent to ER for PICC line replacement family and MD are aware (LPN #1 one name redacted). 8/24/20 at 10:05 PM resident left facility via non-emergent medical transport by stretcher due to right chest Cath PICC line replacement, 2100 meds given prior to discharge, call placed to (hospital name redacted) transfer center spoke to (name redacted) awaiting residents arrival, skin assessment shows no new conditions prior to discharge family and MD aware of departure (LPN name redacted) Excerpts from ER record: Pt. arrived via (transport company name redacted) from (facility name redacted) for PICC line replacement. Pt. has no other complaints. Upon examination, the PICC line looks cut where the hubs should be. On 10/1/20 at 1:20 PM and interview was conducted with RN A who stated that the dressing was intact when she went in there was no leaking. I didn't have scissors with me or nothing. I flushed as like I was supposed to. I hung the antibiotic, then I took it apart I flushed with normal saline and [MEDICATION NAME] and put the cap back. It was intact when I left the room .The next day they told me the port was cut. When asked if she had been received training on the Groshong catheter she stated that she had training in school and at other jobs. The Bard Nursing Procedure Manual for Groshong Central Venous Catheter Page 34 read: Catheter Damage -When catheter damage or connector separation occurs, the catheter should be immediately clamped or kinked closed to prevent any possibility of air embolism or loss of blood. Possible Causes Repeated clamping. Contact with a sharp object. Rupture from attempt to irrigate an occluded catheter with a small syringe. Small syringes can generate very high internal pressures with very little force. The back pressure from an occlusion may not be felt when using a small syringe until damage to the catheter has occurred. B1) Review of clinical records reveals that wound notes up until 8/28/20 do not mention condition or site of wound. On 10/1/20 at 2:13 PM an interview was conducted with the DON and when asked about the documentation of the wound she stated that the nurses should be documenting on the color and appearance of the wound. She added it was hard to tell because the Resident had a dark complexion and was getting [MEDICATION NAME] to her foot as a treatment so it was hard to see how it was doing. She was asked what is incumbent upon the nurse to do during a dressing change. She stated that the nurse should clean the wound before applying the medication so she can visualize the area. She should be documenting any abnormal findings like heat swelling, drainage odor increase in pain and temp. B2) A review of the weekly skin assessments revealed that on 8/21/20 the initial skin assessment was done page 1 of 3 refers to the Surgical incision on 4th digit L foot. Page 2 of 3 section B. 1. 4th digit Left foot, 2. Present on admission, 3. Wound Healed? NO 4. Visible observation of tissue (boxes checked f & g) f. dry and g. blood filled blister. 5. Drainage present NO. The subsequent assessments done on 8/29, 9/1/20 and 9/3/20 all are filled out identically with the same descriptions for 4. Visible Observations of tissue. On 10/1/20 at 2:13 PM an interview was conducted with the DON who was asked why all of the skin assessment sheets are identical when the progress notes on 9/1/20 and 9/3/20 reflect a deterioration in the condition of Resident's foot. She responded that she did not know. The administrator was made aware of the concerns at the end of day meeting on 10/1/20 and no further information was provided.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed provide medications as ordered by physician for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1 the facility failed to provide the correct medications (IV Antibiotics) to treat a post-operative patient resulting in the Resident missing 6 doses of IV antibiotics. Resident #1, a [AGE] year-old woman was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].#1's most recent MDS (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psychiatric treatments. The Resident's weight-bearing status was non weight bearing on the left leg. The MDS coded the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as Z- none of the above indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. A review of the clinical record reveals the discharge instructions from hospital (printed 8/21/20 entered into the facility EHR on 8/21/20) included the following: medications: [REDACTED]. A review of the Physician orders [REDACTED]. Note: The discharge summary from hospital orders were for [MEDICATION NAME] not [MEDICATION NAME] 1 gm every 24 hours. Excerpts from the progress notes are as follows: 8/23/20 at 4:41 PM pharmacy was contacted concerning patient's IV [MEDICATION NAME] they have stated that the order has to be web signed and faxed the order was signed and faxed pharmacy verbalized order we received and medication will be sent out (nurse name redacted). 8/24/20 3:19 PM - skilled note- Patient's Central line to right upper chest, clean dry and intact. Central line flushes well. Received first dose of [MEDICATION NAME] 1 g 12:00 PM. No adverse reactions noted From Medication. 8/24/20 8:02 PM - Resident right chest Cath is inaccessible. No lumen present. No S/S of infection at the site. Order received have Cath changed. Mobile services state they cannot replace a tunneled chest cath. Resident sent non-emergent to (hospital name redacted) for chest Catheter placement. Message left for LTC on-call. Resident informed (family member) of her condition. (LPN #1 name redacted). 8/24/20 at 8:23 PM orders administration note [MEDICATION NAME] HCl solution 1 g/50 ml administration PICC line inaccessible resident sent to ER for PICC line replacement family and MD are aware (LPN #1 name redacted). Excerpts from ER record: Pt. arrived via (transport company name redacted) from (facility name redacted) for PICC line replacement. Pt. has no other complaints. Upon examination, the PICC line looks cut where the hubs should be. Pt. will get IV placed, her first round of antibiotics, observed for possible reaction, and sent back to facility. Informed nurses (2 nurses names redacted) at (facility name redacted) to send patient back to the ED during the daytime when the PICC team is here. (Dr. Name redacted) advised leaving the IV in place for access until the new PICC line is placed. Excerpts from facility progress notes are as follows: 8/25/20 at 7:26 AM skilled note patient returned from ER with IV site in right AC, vitals obtain skin intact no complaints of pain PO [MEDICATION NAME] given call bell and reach patient picked up for [MEDICAL TREATMENT] at 5:15 via wheelchair 8/25/20 at 8:54 PM orders administration note [MEDICATION NAME] 1 g/50 ml use 1 g intravenously every 24 hours for infection related to [MEDICAL CONDITION] of the lower left limb. Administration unable to administer medications due to clogged IV (doctor's name redacted) made aware will follow up with vascular surgeon (LPN name redacted) Excerpts from Physician's note dated 8/25/20 at 12:00 AM read: Since patient has been admitted she has not received a dose of [MEDICATION NAME]. Initially she was started on the wrong antibiotic, [MEDICATION NAME], and received at least three doses of that. Her right Groshong catheter lost its lumen and a peripheral IV was placed last evening. Now this is currently not functioning or flushable. (Note: Review of MAR indicated [REDACTED]. (Nurse's name redacted). A Review of the MAR indicated [REDACTED]. She did not get the correct antibiotics on 8/24/20 at 9:00 PM as ordered (however she got one dose of correct Antibiotic 8/25/20 at midnight at ER) then she did not get her next scheduled dose due to infiltrated peripheral IV. The PICC was not replaced until 8/28/20. She missed a total of 6 doses of [MEDICATION NAME] and was given the incorrect antibiotic 2 times between 8/21/20 and 8/28/20. 10/1/20 2:13 PM an interview was conducted with the DON. She was asked the process for an admission. She stated

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