STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HENRICO HEALTH & REHABILITATION CENTER	**561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075**

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 observation, resident interview, staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to develop a comprehensive care plan for 1 resident (Resident #12) in a sample size of 7 residents. The findings included: For Resident #12, the facility staff failed to address the plan of care for ambulation and assistive devices. Resident #12, an [AGE] year old female, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #12's Minimum Data Set with an Assessment Reference Date of 03/19/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 7 out of possible 15 indicative of severe cognitive impairment. Functional status for transfers was coded as limited assistance meaning resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance with one person for support. Toileting was coded as limited assistance with one person support. Walk in room was coded as 7 meaning activity occurred only once or twice during the 7-day look back period with set up help only for support. Balance during walking was coded as 1 meaning not steady, but able to stabilize without human assistance. Urinary continence was coded as occasionally incontinent. Bowel continence was coded as frequently incontinent. On 09/09/2020, the clinical record was reviewed. An incident note written by Licensed Practical Nurse G (LPN G) dated 05/15/2020 at 8:45 AM documented, Situation: Staff responding to noise observed resident on the floor by sink with right foot twisted under left leg. Resident stated, I was tripping turning around to grab plastic bag on the way to the bathroom. Background: Resident uses a roller walker to ambulate. Assessment (RN)/Appearance (LPN): Resident had ROM (range of motion) in left leg but observed moving right leg/foot slowly. Resident c/o pain with and without movement. Recommendations: Resident educated on importance of utilizing the call bell for assistance. Notified MD/RP (medical doctor/responsible party)-order to send resident out to (hospital) for further evaluation. The Physical Therapy Discharge Summary dated 04/10/2020 at 9:24 AM under the header, Skill and sub-header Interventions Provided documented, Pt (patient) instructed in progressive gait training for improved safety with FWW (front-wheeled walker), improved gait mechanics and decreased risk for falls. Pt instructed in appropriate hand and foot placement, keeping walker close to self and pushing walker with continuous step and increased foot clearance. Instructed in obstacle negotiation to improve safety ambulating in room. Under the sub-header, Neuro re-ed: Tinetti assessment (a test to assess for balance) completed to assess fall risk with resultant score of 14/28 (14 out of possible 28 indicative of high risk for falls).Under the sub-header PT (patient) and Caregiver Training documented, Instructed patient in compensatory strategies, proper body mechanics, safety sequencing techniques, safe transfer techniques and use of assistive device(s) in order to increase safety and decrease need for assistance and increase functional mobility skills with variable carryover demonstrated, facilitating the need for continued supervision in LTC (long term care) environment. The care plan was reviewed. A focus dated 03/17/2020 entitled, The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) generalized weakness included but not limited to the following interventions: Toilet use: The resident is able to: Assist x 1 (need one person to assist). Transfer: The resident is able to: Assist x 1 (need one person to assist). A focus dated 03/17/2020 and revised on 05/15/2020 entitled, Actual fall 05/15/2020 with risk for more falls r/t (related to) deconditioning included but not limited to the following interventions: Assistive devices: Assist bars. Ensure the resident is wearing grip socks, non slip shoes when ambulating or mobilizing in w/c (wheelchair). Interventions addressing ambulation in the room or assistive device needed while ambulating was not addressed in the care plan. On 09/15/2020 at approximately 10:40 AM, an interview via telephone with Licensed Practical Nurse G (LPN G) was conducted. LPN G verified she was the nurse caring for Resident #12 when the fall occurred on 05/15/2020. When asked if Resident #12 needed a walker to ambulate, LPN G stated that during the day, Resident #12 would get around with a walker, but at night she was incontinent and would ring her bell if she needed something at night. On 09/15/2020 at approximately 10:55 AM, an interview via telephone with Certified Nursing Assistant I (CNA I) was conducted. CNA I verified she cared for Resident #12 on the night shift when Resident #12's fall occurred on 05/15/2020. CNA I stated that Resident #12 used a walker when ambulating in her room. During the course of the survey, the facility staff provided a copy of their policy dated 11/01/19 entitled, Care Planning under the header Policy, it was documented, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. On 09/15/2020 at approximately 1:00 PM, the administrator and corporate DON were notified of findings. When asked about expectation of functional status/needs on care plan, the corporate registered nurse (RN) stated she would expect that ambulation and assistive devices would be included on the care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, facility documentation and in the course of a complaint investigation the facility staff failed to review and revise careplan for 2 Residents (#13 and #14) in a survey sample of 7 Residents. The findings included: 1. For Resident #13 the facility staff failed to review and revise careplan to include interventions for significant weight loss. Resident #13, a [AGE] year old man, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #13's most recent MDS with an ARD date of 6/1/20 coded as a quarterly review, coded the resident as having a BIMS of 12 indicating mild cognitive impairment. The resident is coded as using a walker and wheelchair for ambulation, and requiring limited assistance of one person physical assistance with all aspects of ADL care. A review of the clinical record revealed the Resident was seen by physician on 6/9/20 excerpts from the physician notes are as follows: Page 5 of 5 I. Plan: monitor for [MEDICAL CONDITION], monitor for dehydration, increase protein intake, c/w (continue with) present meds. A review of the care plan revealed that Nutrition was addressed as follows: FOCUS-Nutrition Risk related to weight fluctuation d/t history of ETOH (alcoholism) Created on: 4/22/17 Revision on 6/2/20 GOAL - Will avoid significant weight change through next review. Created on 4/22/17 Revision on 8/10/20 Target Date: 10/29/20 INTERVENTION: Monthly Weights Created On 7/13/20 Observe and report to MD difficulty tolerating diet. Created On: 4/18/19 Provide and serve supplements as ordered Created 5/26/20 Provide diet as ordered. Monitor intake and record each meal. Created on: 4/22/17 Revision on 5/4/17 The order for increased protein was not on the care plan. On 9/14/20 at approximately 12:00 PM an interview was conducted with the DON who was asked how staff know how to care for Residents. The

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) DON stated It is in the care plan. When asked who has access to the care plans to update them and who is responsible for updating. The DON stated All of the nurses can add to the care plan and the IDT (interdisciplinary team) also have access to update as they need to. When asked how and when they should be updated she stated They are updated quarterly and with any changes in condition. A review of the care plan policy # 2602 dated 11/02/19 read: Procedure 6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. On 9/15/20 during the end of day conference the Administrator was made aware of the concerns and no further information was provided. 2. For Resident # 14 the facility staff failed to review and revise care plan to include an actual fall and three (3) elopements. Resident #14, an [AGE] year old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 14's most recent MDS (Minimum data set) with an ARD (assessment reference date) of 7/22/20, was a significant change assessment. The MDS coded the resident as having a BIMS (brief interview of mental status) score of 99, indicating the resident was unable to complete the interview due to severe cognitive impairment. MDS section C-1000 Box is checked #3 - Severely impaired never or rarely makes decisions. Section C1310 Signs and Symptoms of [MEDICAL CONDITION] -Acute onset mental status change-box checked is #0 NO was checked box B - Inattention- coded as number 2 - Behavior present fluctuates, comes and goes changes in severity. C -Disorganized thinking- coded the Resident as # 2 -Behavior present fluctuates, comes and goes and changes in severity. The MDS coded the resident as needing assistance with all aspects of ADLs (activities of daily living) the resident was also coded as using a wheelchair for mobility. On 9/9/20 a review of the progress notes revealed that the Resident had a fall on 5/18/20 excerpts from the progress notes are as follows: 5/18/20 at 7:24 PM Post Fall Note Situation: patient fell in another patient ' s room Background: high risk for falls Assessment (RN) /Appearance (LPN) : no complaints of pain no injuries Recommendation: one on one care (LPN name redacted) Review of the progress notes revealed that on 6/14/20 at 7:42 PM Resident did escape the building and was standing in the facility parking lot stating that she's going to the car to drive home I went to get her immediately and kept her sitting with me (RP name redacted) (LPN name redacted). Progress notes entered on 6/26/20 at 2:39 PM read: This nurse along with CNA noted the alarm door going off on the north unit and noted a resident going out of the door. Resident was redirected back into the building and to her room. Wander guard noted to be in place will continue to monitor resident. (Name redacted) Further evaluation of clinical record reveals that on 7/13/ 20 at 6:46 PM Incident Note: Situation: Elopement Background: High risk for falls wanderer. Assessment RN / Appearance LPN: Resident left the premises. Recommendations: Resident needs to be heavily supervised, one to one care, resident will also benefit from bed and chair alarms. (LPN name redacted) The care plan read: Focus resident is at risk for falls r/t confusion. Created on: 10/16/19 Revision on: 9/9/20 Goal: The resident will not sustain serious injury through the review date. Created on: 10/16/19 Revision on: 9/9/20 Target date: 11/5/20 Interventions: Anticipate resident needs a medication review to be done on one 2/2/20 created on one 2/7/20 revision on 9/9/20 assistive devices assist bars high-back wheelchair. Created on: 10/16/19 Revised on: 9/9/20 Be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. Created on: 10/16/19 Revision on: 9/9/20 Give resident option to get out of bed when making attempts to get up 2/2920. Created on: 3/3/20 Revision on: 9/9/20 Redirect resident's behavior 1/13/20 Created on 1/14/20 Revision on: 9/9/20 Redirect resident's behavior when agitated R/T fall 1/5/20 created on 12/11/19 revision on 9/9/20. The fall on 5/18/20 was not added nor were interventions put into place post fall. The care plan also read: FOCUS: is resident is an elopement risk/wanderer R/T resident wanders aimlessly. Created :7/7/20 Revision: 9/9/20 GOAL:The goal the resident safety will be maintained through the review date. Created on : 7/7/20 Revision on: 9/9/20 Target date: 11/5/20 INTERVENTIONS: distract resident from wandering by offering pleasant diversion structured activities food conversation television book resident prefers Created on : 7/7/20 Revision on: 9/9/20 Monitor location notify the nurse of wandering behavior and attempts to leave facility Created on : 7/7/20 Revision on: 9/9/20 The resident triggers for wandering/elopement outside of the building Created on : 7/7/20 Revision on: 9/9/20 Wander alert: resident has wander guard to the lower leg Created on : 7/7/20 Revision on: 9/9/20 The Resident had two elopements one on 6/14/20 and one on 6/26/20 before the care plan was reviewed and revised on 7/7/20 and then had a third elopement on 7/13/20. On 9/14/20 at approximately 12:00 PM an interview was conducted with the DON who was asked how staff know how to care for Residents. The DON stated It is in the care plan. When asked who has access to the care plans to update them and who is responsible for updating. The DON stated All of the nurses can add to the care plan and the IDT (interdisciplinary team) also have access to update as they need to. When asked how and when they should be updated she stated They are updated quarterly and with any changes in condition. A review of the care plan policy # 2602 dated 11/02/19 read: Procedure 6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment.
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** Based on interview, review of clinical records facility documentation and in the course of an investigation the facility staff failed to maintain professional standards of care for 2 Residents (#15 and #3) in a survey sample of 7 residents. The findings include: 1. For Resident #15 the facility staff failed to assess the Resident for need of a Wander Guard before it was applied. Resident # 15, a [AGE] year old woman was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/1/20, coded the Resident as having a BIMS (brief interview of mental status) score of 8 indicating moderate cognitive impairment. On 9/9/20 during clinical record review it was discovered that the Resident had eloped the building on 7/17/20. 7/17/20 3:41 PM - Incident Note Situation - Resident was found heading towards the front entrance. She was brought back to the unit by CNA, who informed the nurse. Background - Resident was assigned a 1:1 for the day, due to a successful elopement on prior shift. The assigned 1:1 reported to the nurse that the resident had hit her in the head, and was attempting to hit her again. 1:1 was then observed walking towards front of the building. Wander guard was applied to right ankle. Assessment (RN) / Appearance (LPN): Resident appeared agitated. No other signs of distress noted. Vital signs are stable. Recommendations: Continue 1:1 observation On 9/10/20 at approximately 2:00 PM a copy of the wander guard assessment from facility staff was requested due to a wanderguard being applied on 7/17/20. However, the corporate nurse said it was not done. On 9/14/20 at approximately 2:00 PM an interview was conducted with the Corporate RN who stated that It is usual procedure to get the wander guard assessment done and then, if needed, get an order for [REDACTED]. According to Nursingworld.org (American Nurses Association website) ANA Standards of Professional Nurse Practice Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation. On 9/15/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #3, the facility staff failed to perform neurological assessments after an unwitnessed fall on 04/11/2020. Resident #3, a [AGE] year old male, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set with an Assessment Reference Date of 02/15/2020 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility was coded as requiring extensive assistance from staff with two+ person physical assistance from staff for support. Functional status for transfers was coded as requiring extensive assistance from staff with one+ person physical assistance from staff for support. The closed record was reviewed. A nurse's note written by Licensed Practical Nurse H (LPN H) dated 04/11/2020 at 8:46 PM documented, Situation: Resident found lying on the ground face first near for the bed. Background: Resident is double AKA (above-the-knee amputation) bilateral. Resident is 2- person assist. Assessment (RN)/Appearance (LPN): Resident denies pain. No new skin impairments. Resident noted with SOB (shortness of breath) and respirations of 24. All other vitals are stable at this time. Recommendations: reinforce instructions on use of call bell. A note entitled, Orders - Administration Note written by Licensed Practical Nurse D (LPN D) dated 04/11/2020 at 10:18 PM documented, [MEDICATION NAME] Tablet Gave 500 mg by mouth every 6 hours as needed for pain. Follow-up pain scale was : 7 (pain level severity). PRN (as needed) administration was: Ineffective. The Vitals Summary were reviewed for 04/11/2020 and 04/12/2020. Under the header O2 Sats (oxygen saturation) Summary it was documented, 04/11/2020 at 8:21 PM, it was documented, 96% (oxygen via nasal cannula). There were no other subsequent entries for oxygen saturation. Under the header Temperature Summary it was documented, 04/11/2020 at 4:03 PM 97.3 F (degrees Fahrenheit) 04/12/2020 at 1:30 AM 97.3 F. There was no documentation of blood pressure, pulse, or respirations on the flowsheet for 04/11/2020 or 04/12/2020. On 09/10/2020 at 3:30 PM, an interview via telephone was conducted with LPN D. LPN D confirmed she was the nurse caring for Resident #3 on 04/11/2020 for the 7p-7a shift. When asked if neuro checks were done after the fall, LPN D stated that Resident #3 did not fall on her shift and when she came in at 7pm, the neuro check were just about done, she only had one more set of vital

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) signs to obtain. When asked where neuro checks are documented, LPN D stated on a piece of paper. When asked about the location of pain regarding the administration note she wrote on 04/11/2020 at 10:22 PM, LPN D stated He said he had a headache. LPN D then stated she couldn't remember. When asked if Resident #3 complained of feeling short of breath, LPN D stated Resident #3 was not having shortness of breath and added, I asked him. LPN D also stated that about 2:00 AM, she and an agency CNA pulled him up in bed and stated that Resident #3 requested Tylenol for pain at that time. On 09/10/2020 at 5:15 PM, a copy of the neuro checks was requested and the corporate RN, Employee C, verified that neuro checks for Resident #3 were not scanned in to the clinical record and could not be located. When asked about the expectation after an unwitnessed fall, Employee C stated that the expectation is that the staff would perform a neuro assessment, assess for pain, bruising, and to notify the MD. Employee C also stated the expectation is that the neuro checks would be scanned into the clinical record in a timely fashion. The facility staff provided a copy of their policy entitled, Neurological Assessment. Under the header Policy, it was documented, A Neurological Assessment will be completed by a licensed nurse in order to detect potential early signs of [MEDICAL CONDITION] usually in response to a traumatic patient event. The headers for Sections 2 through 6 were as follows: Assess Level of Consciousness; Assess pain response; Assess pupil response; Assess muscle strength; Assess reflexes. In Section 8, it was documented, Record findings on the neurological Assessment Form. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next 4 hours. According to Lippincott Nursing Procedures, Seventh Edition, 2016, under the section entitled, For Fall Management, it was documented, Monitor the patient's status for the next 48 hours or for a period determined by your facility and the patient's condition.
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 observation, interview, and clinical record review and in the course of a complaint investigation it was found that the facility failed to ensure freedom from accidents and hazards for 2 Residents (#14 & 15) in a survey sample of 7 Residents. The findings included: 1. For Resident #14 the facility staff failed to prevent her exiting the building unsupervised. Resident #14, an [AGE] year old woman admitted to the facility with [DIAGNOSES REDACTED]. Resident # 14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/22/20 was coded as a Significant change MDS, coded the Resident as having a BIMS (brief interview of mental status) score of 99 indicating the resident was unable to complete the interview. MDS section C-1000 Box checked #3 - Severely impaired never or rarely makes decisions. Section C1310 Signs and Symptoms of [MEDICAL CONDITION] - Checked box B - Inattention - coded as number 2 - Behavior present fluctuates, comes and goes changes in severity C -Disorganized thinking - coded the Resident as # 2 -Behavior present fluctuates, comes and goes and changes in severity. The MDS coded the resident as needing assistance with all aspects of ADLs (activities of daily living) the resident was also coded as using a wheelchair for mobility. On 9/9/20 during the entrance conference the Administrator was asked to provide any FRI's (Facility Reported Incidents) concerning elopements in the past six months for any resident. The administrator supplied one FRI for this Resident dated 7/13/20. When asked if there were any other elopements he stated Not that I am aware of. On 9/9/20 a review of the clinical records revealed that the Resident had elopements from the building on 6/14/20, 6/26/20 and 7/13/20. Excerpts from the progress notes are as follows: 6/14/20 at 7:42 PM Resident did escape the building and was standing in the facility parking lot stating that she's going to the car to drive home I went to get her immediately and kept her sitting with me (RP name redacted) (LPN name redacted). 6/26/20 at 2:39 PM This nurse along with CNA noted the alarm door going off on the north unit and noted a resident going out of the door. Resident was redirected back into the building and to her room. Wander guard noted to be in place will continue to monitor resident. (Name redacted) 7/13/20 at 6:46 PM Situation: Elopement Incident Background: High risk for falls wanderer. Assessment RN / Appearance LPN: Resident left the premises. Recommendations: Resident needs to be heavily supervised, one to one care, resident will also benefit from bed and chair alarms. (LPN name redacted) On 9/15/20 the during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2.For Resident #15 the facility staff failed to ensure a Resident did not leave building unsupervised. Resident # 15, a [AGE] year old woman was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/1/20, coded the Resident as having a BIMS (brief interview of mental status) score of 8 indicating moderate cognitive impairment. She was also coded under section C 1310 - A - Acute onset of mental status changes. Is there an acute change in mental status from baseline? 1. Yes C. Disorganized thinking - 2. Behavior Present comes and goes and changes in severity. D Altered level of consciousness - 2. Behavior Present comes and goes and changes in severity On 9/9/20 during clinical record review it was discovered that Resident had become increasingly confused and exit seeking in the week before she eloped the building on 7/17/20. Excerpts from the progress notes are as follows: 7/12/20 23:28 (11:28 PM) Health Status Note - Resident presented with severe confusion, agitation, hallucinations. Resident stated someone stole my cigarette. Resident stated I need to leave so my dad can come get me. A review of the progress notes revealed the following 7/17/20 at 5:27 AM Resident was agitated during the night she stated her mom was coming to get her. (RN name redacted) 7/17/20 at 7:15 AM - Incident note Situation -Resident left the building stating 'she was going to smoke a cigarette' Staff got her back in the building MD (name redacted) and RP (name redacted) called. Background - Resident currently has UTI Assessment (RN) / Appearance (LPN) -Resident is agitated Vitals WNL Denies pain and discomfort. Recommendations - Will continue to monitor (RN name redacted) 7/17/20 3:41 PM - Incident Note Situation - Resident was found heading towards the front entrance. She was brought back to the unit by CNA, who informed nurse. Background - Resident was assigned a 1:1 for the day, due to a successful elopement on prior shift. The assigned 1:1 reported to the nurse that the resident had hit her in the head, and was attempting to hit her again. 1:1 was then observed walking towards front of the building. Wander guard was applied to right ankle. Assessment (RN) / Appearance (LPN): Resident appeared agitated. No other signs of distress noted. Vital signs are stable. Recommendations: Continue 1:1 observation Note: The wanderguard order was not obtained until Resident #15 made a second attempt at elopement on 7/17/20. On 9/15/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, clinical record review and facility documentation the facility staff failed to ensure nutrition interventions were in place 1 of 7 Residents (Resident #13) to prevent weight loss. The findings included: For Resident #13 the facility staff failed to implement interventions to prevent a 20 pound weight loss in less than 6 months. Resident #13, a [AGE] year old man, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #13's most recent MDS with an ARD date of 6/1/20 coded as a quarterly review, coded the resident as having a BIMS of 12 indicating mild cognitive impairment. The resident is coded as using a walker and wheelchair for ambulation, and requiring limited assistance of one person physical assistance with all aspects of ADL care. On 9/9/20 during clinical record review it was noted that Resident #13 had a decrease in weight from 185 lbs. on 4/2/20 to 164.2 lbs. on 9/15/20. This 20 lb. weight loss represents a decrease in body weight of 10.92% in less than 6 months. A review of the clinical record revealed the Resident was seen by physician on 6/9/20 excerpts from the physician notes are as follows: Page 5 of 5 I. Plan: monitor for [MEDICAL CONDITION], monitor for dehydration, increase protein intake, c/w (continue with) present meds. A review of the record revealed no additional protein supplements were ordered for this Resident. On 9/15/20 at 2:00 PM an interview was conducted with the DON who was asked if the order for increased protein should have been added to the physicians order or referred to the dietician, she stated that It should have been referred to the dietician to make recommendations for protein supplements like Prostat or fortified foods with extra protein. It also should have been careplanned under nutrition. On 9/15/20 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is**

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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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and facility documentation the facility staff failed to ensure Residents do not receive unnecessary [MEDICAL CONDITION] drugs for 1 Resident (#14) in a survey sample of 7 Residents. The findings include: For Resident #14 the facility staff failed to ensure the [MEDICATION NAME] PRN order was discontinued or properly documented after 2 weeks. Resident #14 an [AGE] year old woman admitted to the facility with [DIAGNOSES REDACTED]. Resident # 14's most recent MDS (Minimum data set) with an ARD (assessment reference date) of 7/22/20, was coded as a significant change assessment. The MDS coded the resident as having a BIMS (brief interview of mental status) score of 99, indicating the resident was unable to complete the interview. MDS section C-1000 Box is checked #3 - Severely impaired never or rarely makes decisions. Section C 1310 Signs and Symptoms of [MEDICAL CONDITION] -Acute onset mental status change-box checked is #0 NO was checked box B - Inattention - coded as number 2 - Behavior present fluctuates, comes and goes changes in severity C -Disorganized thinking - coded the Resident as # 2 -Behavior present fluctuates, comes and goes and changes in severity. The MDS coded the resident as needing assistance with all aspects of ADLs (activities of daily living) the resident was also coded as using a wheelchair for mobility. During clinical record review on 9/14/20 it was noted that the Resident had an order that read : [MEDICATION NAME] 0.5 mg (milligrams) ([MEDICATION NAME]) Give 0.5 mg every 4 hours as needed for agitation / comfort This order was started on 1/25/20 and did not end until 8/4/2020. On 5/15/20 at approximately 1:15 PM the DON was asked about the prolonged PRN [MEDICATION NAME] order and she stated She was a hospice patient. The facility provided three pharmacy consultation report that read: (Resident name redacted) has a PRN order for [MEDICATION NAME] without a stop date. She is under hospice care. Recommendation: Please discontinue [MEDICATION NAME] after 14 days. If the medication cannot be discontinued at the is time, current regulations require the prescriber document: The indication for use _____ (left blank) the intended duration of therapy _____(left blank) and rational for extended time period____(left blank) Rationale for recommendation: CMS requires that PRN orders for non anti psychotic [MEDICAL CONDITION] drugs be limited to 14 day unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period and the duration for the PRN ORDER. Physicians Response (box checked) I decline the recommendations above and do not wish to implement any changes due to the reason below. Under hospice (physician name redacted) (note: the physician did not indicate reason, duration of therapy and rationale for extended time period) The DON stated that she was an interim DON and this issue was before she started working there. She stated that the medication was discontinued on 8/3/20 because the Resident came off of Hospice on 7/16/20. On 9/15/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.
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 interview, review of clinical records facility documentation and in the course of an investigation the facility staff failed to maintain accurate clinical records for 1 Resident (#14) in a survey sample of 7 residents. The findings included: 1. For Resident # 14 the facility staff failed to accurately complete wanderguard assessment. Resident #14 an [AGE] year old woman admitted to the facility with [DIAGNOSES REDACTED]. Resident # 14's most recent MDS (Minimum data set) with an ARD (assessment reference date) of 7/22/20, was coded as a significant change assessment. The MDS coded the resident as having a BIMS (brief interview of mental status) score of 99, indicating the resident was unable to complete the interview. On 9/9/20 a review of the clinical records revealed that the Resident had elopements from the building on 6/14/20, 6/26/20 and 7/13/20. Progress notes entered on 6/26/20 at 2:39 PM read: This nurse along with CNA noted the alarm door going off on the north unit and noted a resident going out of the door. Resident was redirected back into the building and to her room. Wander guard noted to be in place will continue to monitor resident. (Name redacted) The record showed an incomplete wanderguard assessment. On 9/14/20 at approximately 2PM and interview was conducted with the Corporate RN who stated that It is usual procedure to get the wanderguard assessment done and if needed get an order for [REDACTED]. On 9/15/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.