STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BONVIEW REHABILITATION AND HEALTHCARE	**7246 FOREST HILL AVE RICHMOND, VA 23225**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility staff failed to review and revise the comprehensive care plan for 1 Residents (#1) in a survey sample of 5 Residents. The findings included: For Resident #1 the facility staff failed to review and revise the care plan and add new interventions after each fall. Resident #1, a [AGE] year old man admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/31/20 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 6 indicating severe cognitive impairment. Also the MDS Section G- Functional Status, B. Transfers -independently with 0 physical assistance. Section C. Walking in the room [ROOM NUMBER]. Supervision, 1. Set up help only. Section D. walking in the corridor 1. Supervision, 1. Set up help only. Section E. & F. Locomotion On and Off the unit 1. Supervision, 1. Setup help only. Section G 0600 - Coded the Resident as using a wheelchair for mobility. On 9/23/20, a review of the clinical record revealed that Resident #1 had 8 falls during his stay at the facility from 5/23/20 until 9/4/20. The admitted s are as follows: 6/10/20 -7/30/20 - 8/08/20 -8/18/20 -8/20/20 -9/02/20 -9/03/20 -9/04/20, the last one ending with an admission to the hospital. A review of the care plan revealed The Resident was care planned for falls as follows: FOCUS: (Resident name redacted) has had an actual fall with Poor Balance. Date Initiated 6/10/20 GOAL: The resident will resume usual activities and minimize the risk of further incident through next review date. Date Initiated - 6/10/20 Revision on : 6/11/20 Target date 12/2/20. INTERVENTIONS: Closer Observation Date Initiated - 9/2/20 Revision On: 9/7/20 (note revision after resident was discharged and admitted to the hospital) Neuro checks as ordered-Date Initiated 9/2/20 (Note this is not an intervention this is done post fall) Medication Review - Date Initiated 7/31/20 Provide appropriate activities and guided exercises as tolerated. Date Initiated - 8/9/20 PT consult for strength and mobility. Date Initiated 6/10/20 Revision on 6/11/20 X-Ray as ordered Date Initiated - 6/10/20 (Note: this is not an intervention this is a doctor's order post fall) FOCUS: (Resident name redacted) is at risk for falls r/t confusion, dementia, incontinence, [MEDICAL CONDITION], diabetes, and hypertension. Date Initiated 6/16/20 Revision on 6/16/20: GOAL: Minimize risk of falls through next review date. Date Initiated - 6/16/20 Target date 12/2/20. INTERVENTIONS: Anticipate and meet the resident's needs Date Initiated - 6/16/20 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated 6/16/20 Bed in low position - Date Initiated 6/16/20 Educate the resident / resident's representative / caregivers about safety reminders and what to do if a fall occurs Date Initiated - 6/16/20 Ensure the resident is wearing appropriate footwear/non skid socks when ambulating Date Initiated - 6/16/20 PT evaluate and treat as ordered or PRN. Date Initiated 6/10/20 The care plan was not updated and no additional interventions were put in place for the falls on 8/18, 8/20, 9/3, and 9/4. On 9/24/20 at approximately 1:30 PM an interview was conducted with the DON who was asked about the term Closer observation mentioned in the care plan. She stated that after the Resident fell on [DATE] the Nurse implemented 15 minute checks. On 9/24/20 at the end of day meeting the Administrator was made aware of the concerns and no further information was provided.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation the facility staff failed to provide necessary assistance with ADL's for 1 Resident (#3) in a survey sample of 5 Residents. The findings included: For Resident #3 the facility staff failed to assist the Resident with showering on her assigned 2 days a week, instead she was given either partial or bed bath. Resident number #3, a [AGE] year-old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #3's most recent MDS (minimum data set) coded as a quarterly review with an ARD (assessment reference date) of 8/30/20, coded the Resident as having a BIMS (brief interview of mental status) score of 15 indicating no cognitive impairment. The MDS section G functional status coded the resident as requiring limited assistance with 1 person physical assistance aspects of ADL care with the exception of eating she was independent she was also coded as using a walker for mobility. On 9/24/20 at approximately 11:00 AM an interview was conducted with the Resident who stated that sometimes I try to get up by myself because I can't wait when my old bladder tells me to go I have to go I can't wait I put on the bell and if they can't get here fast enough I have to go. She further stated that she would like to wash her hair as she has not had a shower since arriving at the facility. She stated she had washed her hair once in the sink with the help of a CNA. She was asked how she bathes and she stated bird baths. When asked what a bird bath is she said you know wash up at the sink. On 9/24/20 during the end of day meeting the Administrator was made aware of the comments the Resident made about not getting a shower since arriving at the facility, and copies of the bath schedule were requested as well as CNA documentation of ADL care provided. Copy of the bath schedule revealed that the resident was scheduled to receive a bath on Sunday and Wednesday. CNA shower documentation sheets dated 5/16/20, 6/30/20 and 8/14/20 were reviewed. The facility also submitted the print out from the electronic medical record that shows the Resident was coded on 8/14/20 as receiving BB according to the legend it stands for bed bath. The other 7 times in the month the resident was coded as P indicating partial bath. For the month of September she has gotten 2 BB and 7 partial baths. On 9/25/20 at 9:30 AM an interview with the Corporate Nurse was conducted and she stated they should be filling in the bath or shower, and coding the assistance provided. The CNA's should report any refused showers to the nurse, and the nurse should document any refusals. On 9/25/20 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.
F 0689 **Level of harm** - 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 interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to ensure Residents are free from accidents and hazards for 1 Residents (#1) in a survey sample of 5 residents, resulting in hospitalization for Resident #1. This is harm. The findings included: 1. For Resident #1 the facility staff failed to provide adequate supervision to ensure the resident was free from accident hazards. Resident #1 had 8 falls in 4 months. He fell on [DATE] (complained of pain to right shoulder however x-ray was negative for fracture); 7/30/20 (Laceration to left eyebrow and skin tear to left elbow. Sent to ER for evaluation, returned with

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) sutures to left eyebrow area.; 8/08/20 (skin tear to left elbow); 8/18/20 (skin tears to left hand and wrist); 8/20/20 (No injury noted); 9/02/20 (laceration over left eye, 3 skin tears to left arm. Sent to ER for evaluation. Returned with 4 sutures over left eye); 9/03/20 (abrasion on right upper arm, skin tear to right hand and hematoma on right side of forehead. Sent to ER. Head CT negative, X-ray of right arm negative). His last fall was on 9/04/20 when he was admitted to the hospital for left maxilla (upper jaw) fracture, left orbit (eye socket) fracture and left zygomatic (cheekbone) arch fracture and mildly displaced Left lateral sixth -eighth rib fractures and Posterior left fourth and fifth rib fractures. This is harm. Resident #1, a [AGE] year old man admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/31/20 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 6 indicating severe cognitive impairment. Also the MDS Section G-Functional Status, B. Transfers -independently with 0 physical assistance. Section C. Walking in the room [ROOM NUMBER]. Supervision, 1. Set up help only. Section D. walking in the corridor 1. Supervision, 1. Set up help only. Section E. & F. Locomotion On and Off the unit 1. Supervision, 1. Setup help only. Section G 0600 - Coded the Resident as using a wheelchair for mobility. On 9/23/20 a review of the clinical record revealed that Resident #1 had 8 falls during his stay at the facility from 5/23/20 until 9/4/20. A review of the care plan revealed The Resident was care planned for falls as follows: FOCUS: (Resident name redacted) has had an actual fall with Poor Balance. Date Initiated 6/10/20 GOAL: The resident will resume usual activities and minimize the risk of further incident through next review date. Date Initiated - 6/10/20 Revision on: 6/11/20 Target date 12/2/20. INTERVENTIONS: Closer Observation Date Initiated - 9/2/20 Revision On: 9/7/20 (note revision after resident was discharged and admitted to the hospital) Neuro checks as ordered-Date Initiated 9/2/20 (Note this is not an intervention this is done post fall) Medication Review - Date Initiated 7/31/20 Provide appropriate activities and guided exercises as tolerated. Date Initiated - 8/9/20 PT consult for strength and mobility. Date Initiated 6/10/20 Revision on 6/11/20 X-Ray as ordered Date Initiated - 6/10/20 (Note: this is not an intervention this is doctors order post fall) FOCUS: (Resident name redacted) is at risk for falls r/t confusion, dementia, incontinence, [MEDICAL CONDITION], diabetes, and hypertension. Date Initiated 6/16/20 Revision on 6/16/20: GOAL: Minimize risk of falls through next review date. Date Initiated - 6/16/20 Target date 12/2/20. INTERVENTIONS: Anticipate and meet the resident's needs Date Initiated - 6/16/20 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated 6/16/20 Bed in low position - Date Initiated 6/16/20 Educate the resident / resident's representative / caregivers about safety reminders and what to do if a fall occurs Date Initiated - 6/16/20 Ensure the resident is wearing appropriate footwear/nonskid socks when ambulating Date Initiated - 6/16/20 PT evaluate and treat as ordered or PRN. Date Initiated 6/10/20 (Note: The care plan was not updated and no interventions were put in place for the falls on 8/18, 8/20, 9/3, and 9/4) On 9/23/20 at 1:25 PM an interview was held with the ADON who was asked what the nurse should do if a fall occurs. She stated Well first you assess to see if the Resident is hurt. Then you check the vital signs, start neuro checks if it is unwitnessed or if they hit their head, contact the MD and the RP, fill out a SBAR or change in condition form, chart a nurses note and update the care plan with new interventions after each fall. She was asked who does the care planning is it any nurse or does one person have that job, she stated, All nurses have access to update the care plan. On 9/24/20 approximately 2:00 PM requested a list of all of the falls from 4/1/20 through 9/24/20 the facility submitted a list that included seven of the eight falls that Resident 1 sustained. The list was missing the fall on August 18. On 9/24/20 at approximately 10:30 AM and interview with the DON and ADON and Corporate Nurse was held. The survey team requested copies of the fall investigations for all falls sustained by Resident #1 during his admission. The DON was asked what the nurses responsibility when there is a fall. She replied She should assess the Resident, notify the MD/RP, write a note in the chart, complete an SBAR or Change of Condition and if it is unwitnessed or the Resident has a head injury they should to neuro checks as well. The first fall occurred on 6/10/20. A nursing note dated 6/10/20 at 1:50 PM the note reads: Late entry patient found on the floor between the bed and the window laying on his left side. Patient assessed able to move all extremities, however guard to the left arm VS 117/68, 71, 20, 97.7, Neuro checks initiated within normal limits when asked what he was trying to do, patient responded lift the bed. Nurse asked what for I said to tighten the bolts earth asked (NP name redacted) to see patient new order for stat CBC/CMP/urine and obtain x-rays of left shoulder and left humerus. Left VM (voicemail) for RP (name redacted) to call facility awaiting call back will continue to monitor for changes. LPN (name redacted). Note: The facility stated they could not locate the neuro flow sheet for this unwitnessed fall The second fall occurred on 7/30/20. Nurse's note dated 7/30/20 at 7:25 PM reads: VS-BP 137/72 HR - 65, T - 96.2 RR - 20 SPO2 -92% Resident was found on the floor laying on the left side. Laceration noted to the left upper eye; skin tear to left elbow. Resident is awake, conscious, and breathing. Resident was sent out via stretcher. EMS was given face sheet, order summary/medication list. Gave report to (name redacted) at (hospital name redacted) faxed over face sheet, SBAR, hospital transfer form. Notified nurse that patient has no present signs or symptoms of COVID-19 will follow up with resident status (LPN name redacted). The results of a fall risk evaluation dated 7/31/20 read that the resident is a High fall risk. A physicians note dated 7/31/20 reads: Chief Complaint/Nature of Presenting Problem: Fall f/u and laceration above the eye. Resident seen and examined. All medications, labs and medical records were reviewed. Discussed plan of care with nursing staff in detail resident sustained [REDACTED]. Monitor for signs six symptoms of infection remove sutures on 8/7/20 continue with all other medications along with safety and fall precautions (NP name redacted) 7/31/20 11:57 PM The facility submitted a fall risk evaluation dated 8/8/20 at 5:30 PM, again indicating that the resident is a High fall risk, A nurses note dated 8/8/20 read: 8/8/20 at 5:30 PM resident was found on the floor lying on his back. Skin tear noted to the left elbow; minimal bleeding noted. Site cleansed with normal saline and covered with dry dressing. No changes in cognitive status. NP/RP/notified. Will continue to monitor for bleeding and bruising (LPN name redacted). Regarding the fall on 8/18/20 6:03 PM the facility did not have fall investigation. A nurse's note dated 8/18/20 read as follows: 8/18/20 at 8:03 patient was trying to get into the empty bed located in his room and fell on the floor, patient was found on his left side, patient stated that he did not hit his head on anything just his hand and elbow, patient has skin tears to the left hand, wrist, VSS 128/82 -82 -18 - 98% 97.9 patient is easily redirected but he's noncompliant with trying to get back into the other bed, patient seen multiple times trying to get into the bed and was redirected to his bed, patient does not understand that he just fell from the bed that he's trying to get into. Patient does have slip resistant socks. (LPN name redacted) No mention of Neuro checks were in the notes also no Neuro check sheet provided to the survey team. For the fall on 8/20/20, the facility submitted an SBAR/ change and condition form, Root cause analysis investigation, and a neuro check sheet. A nurses note dated 8/20/20 read: 8/20/20 at 11:31 AM resident observed sitting on the floor by his bed wearing his brief but no gown, resident states he was trying to get into the bathroom. No injury noted. Neuro checks started. VSS (vital signs stable) RP/NP notified. (LPN name redacted). The fall investigation again stated that the Resident is a high fall risk. The root cause analysis form stated Observed Resident sitting on the floor, in front of his bed. He said he fell trying to go to the bathroom. For the fall on 9/2/20 at 10PM, the facility submitted an SBAR/ change of condition form that read: Resident was restless most of the shift requiring continuous redirection. At 7 PM was ambulating in his room tripped and fell resulting in a laceration, contusion above the left eye and three skin tears to the left arm the resident was sent to the ER for evaluation. Record review revealed no nurses note in the chart for the fall or when he was sent out to the ER, however there is a note on his return from the ER 9/3/30 at 1:30 AM and it read as follows: Patient arrived back from (hospital name redacted) via stretcher and EMT 99.7-89-22-156/90-95% on RA. 4 sutures to laceration over left eye, swelling has nearly close the eye and bruising is dark. Pt. is alert and verbal with LOC (level of consciousness) consistent with baseline. Pupils equal round reactive to light with accommodation. Patient is walking and moving all extremities. Hand grasps are equal denies headache or nausea no vomiting or [MEDICAL CONDITION] activity observed patient does express memories of the fall RP/MD aware. (LPN name redacted) For the fall on 9/3/20 at 10:00 PM a nursing note read: Patient was constantly redirected and made aware of safety limitation for the first few hours of the shift. He would not stop exiting his room. Patient also would bend over to pick up things off the floor. Many times being a scuff mark on the floor tiles. Patient found in doorway seconds after falling. Patient landed on right side is causing a large abrasion to the upper right arm skin tear on right hand and hematoma on the right side of his forehead. Some bleeding from the hematoma was stopped with slight pressure for a few seconds. Initially patient did not complain of pain. Neurological assessment showed no abnormalities. After about 20 minutes the patient began to complain of severe pain in his shoulder and was requesting to go to the hospital. MD notified patient was sent to hospital name rejected for evaluation with a copy of meds, face sheet, bed hold policy, care plan. MD/ RP notified. (LPN name redacted) The facility submitted the investigation of the fall along with copy of Neuro checks started at 10:00 PM, after the fall. The facility also initiated 15 minute checks after the fall on 9/3/20. The neuro

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) checks and 15 minute checks were signed off at 10:00 and 10:15 PM and then restarted at 3:00 AM (9/4/20) when the resident arrived back to the facility from the ER. For the fall on 9/4/20 at 6:00 AM, the nurse's note read: Patient found on floor in the hallway with head sutures over right brow intact however bleeding. Bleeding stopped with light pressure. Large skin tear to left arm. Patient's neck stabilized by hand support with a pillow and EMT transport was cold at patient side. Pupils equal round and reactive to light with accommodation. Patient would not stop attempting to get up initially and required constant verbal assurance and direction. 30 minutes prior resident name redacted awoke and was redirected with snacks. After eating snacks he fell asleep again less than five minutes prior to the fall patient was asleep in his bed witnessed by rider RP/MD notified of transferred to hospital name redacted picked up by EMT's via stretcher in route at this time 9/4/20 at 6:00 AM.(LPN name redacted). An interview was conducted on 9/25 at 4:07 PM with LPN A via telephone: LPN A was asked did the facility notify him that we would be calling he stated that they did because they can't find the Neuro check sheet that he did. LPN A said that Resident #1 had a fall on 9/2/20 and he broke his glasses but it as it turns out those weren't his glasses those were reading glasses he had bifocals. LPN A stated that, It was the worst night in my nursing career I had two residents that I sent out that we're desaturating due to COVID and Resident #1 kept falling. He also stated I did not witness the fall but I heard him fall. On the third I found him on the floor he had to be sent out to the emergency room Neuro checks re-started and I called the responsible party. The CT scan was negative and the x-ray of his arm was negative . He came back around 3:30 in the morning we resumed his 15 minute checks. He was last checked on at 5:30 then at 6:00 AM I went to get my med cart and I found him in the hallway. LPN A stated that he had filled out the 15 minute checks until he went to get his cart. The Resident went to theER on [DATE] at 6:00 AM and was admitted . LPN A also stated that the resident really needed a one to one but quite frankly we just didn't have the staff to do it. He stated there was 17 patients and one nurse and one CNA on the COVID unit that he was working on that night. After the interview with LPN A, a review of the 15 minute check sheet revealed that the Resident was last checked at 5:30 AM and then was found on the floor at 6:00 AM . There is no documentation of the Resident being checked at 5:45 AM. A review of the hospital records reveal the Resident was seen in the ER and admitted to the hospital for [DIAGNOSES REDACTED]. On 9/25/20 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.