STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT EMPORIA	**200 WEAVER AVENUE EMPORIA, VA 23847**

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 0604 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure one Resident, Resident #1, of three residents in the survey sample was free from application of physical restraints. This resulted in psychosocial harm for Resident #1. The findings included: For Resident #1, the facility staff failed to prevent a CNA (Certified Nursing Assistant) from restraining Resident #1 in a wheelchair. Resident #1, a [AGE] year old male, was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/2019 was coded as an entry assessment. Resident #1 was coded a BI[CONDITION] (Brief Interview of Mental Status) score of 15/15 which indicated no cognitive impairment. Resident #1 required total dependence of one person for his activities of daily living and was always incontinent of bowel and bladder. He used a wheelchair to navigate through the facility. On [DATE]20 at 12:15 PM an interview was conducted with Employee A, Administrator and Employee B, Director of Nursing during the complaint investigation. They stated that CNA A and LPN (Licensed Practical Nurse) A went into Resident #1's room on 2/5/2020 and found Resident #1 in his wheelchair with a seat belt and a sheet securing him to a wheelchair. They released the belt and sheet. CNA B was caring for Resident #1 at that time and they feared for reprisal from him if they reported the incident. On [DATE] CNA A reported the incident to Employee B, Director of Nursing. These facts are supported by signed statements from CNA A and LPN A There was a statement from CNA B who stated that I got him (Resident #1) up off the floor to his wheelchair and put the seatbelt on him. Employee A, Administrator; Employee B, Director of Nursing: and Employee C, Staff Development Coordinator interviewed Resident #1 on [DATE] at 9:45 AM regarding the incident. Resident #1 stated that (CNA B) put him on the floor on his fall mat and told him that you are going to sleep there tonight. Resident #1 also stated that he later came back in the room and body slammed me into the wheelchair and tied a sheet around me to keep me in the wheelchair. He denied any injuries or pain after the incident. Facility management instituted a Plan of Correction, thus making this violation a Past Non-Compliance deficiency. The Plan of Correction was as follows: 1. The facility failed to prevent, investigate, and report an allegation of physical abuse on or about 2/5/2020 for one resident. The resident is still a current resident in the facility. 2. All residents have the potential to be affected by this deficient practice. The facility conducted interviews screening for abuse and neglect. Residents with a BI[CONDITION] score of greater than 8 were interviewed on [DATE]. Residents with a BI[CONDITION] score less than 8 will have family interviews conducted screening for abuse. Any identified concerns that were discovered during the interviews will be immediately addressed according to the facility abuse and neglect policy. 3. Allegation of abuse was brought to the attention of the Director of Nursing on [DATE] by the facility unit manager and reported to the appropriate agencies on [DATE]. The facility began an investigation of the allegation of abuse that had occurred on or about 2/5/2020. Education on Abuse and Neglect, Elder Justice Act, sexual abuse, and reporting requirements was conducted with the Interdisciplinary Team (IDT) on [DATE] by the Regional Director of Clinical Services Facility staff to include the nursing department, respiratory therapy, dietary, housekeeping, laundry, administration, therapy, agency staff, and activity staff will receive training on Abuse and Neglect Policy, Prevention, sexual abuse, Elder Justice Act, and reporting requirements starting on [DATE]. Beginning 2/22/2020 no employees will be allowed to return to work until training has been completed. Administrator will attend resident council on 2/21/2020 and discuss abuse prohibition and reporting channels to ensure all residents are familiar with expectations. 4. Beginning on 2/22/2020 Administrator will monitor compliance with reporting suspected abuse. The Director of Social Service will interview a random sample of 5 residents weekly, conducting resident or family interviews as indicated of a BI[CONDITION] score of 8 or above. Results of weekly audits will be submitted to the administrator weekly. Results will also be reported monthly to the QAPI (Quality Assurance Process Improvement) committee. The QAPI committee is responsible for ongoing monitoring of compliance. 5. Allegation of Compliance (AOC) 2/22/2020. The Plan of Correction was signed by Employee A, Administrator The survey team verified compliance on [DATE]20.

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.