| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **495115** | A. BUILDING _____ B. WING _____ | **09/02/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER** | **831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834** |

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) |
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| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to notify the Resident's physician and family of an incident for one Resident (Resident #2) in a survey sample of 3 residents. For Resident #2 the facility staff failed to notify the Resident's family and physician of an incident/fall. The findings included: Resident #2 was admitted to the facility on [DATE] and discharged on [DATE] to a hospital. [DIAGNOSES REDACTED]. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/2020 was coded as an admission assessment. Resident #2 was coded as having short and long-term memory impairment. Resident #2 was coded as having required extensive assistance of staff with transfers, dressing, personal hygiene, toileting and bathing. On 9/1/2020 & 9/2/2020 during a review of the entire clinical record, to include electronic record and paper chart, it was revealed that there was no documentation of a fall on 3/14/2020, any family or physician notification of the incident until 3/17/2020. On 3/17/2020 there was an entry made into the electronic clinical record by the Director of Nursing (DON/Employee B) that read, Administrator and writer spoke to RP (responsible party) /(relationship redacted) regarding fall in bathroom on Saturday 3/14/2020 and RP informed us she was not informed of the fall - we informed her we would investigate and call her of findings - spoke to assigned nurse at home, she said she did not call RP, reported (Resident #2 name redacted) was in bed and on rounds by CNA (certified nursing assistant)(Resident #2 name redacted) was observed in the bathroom sitting on floor in front of her wheelchair. On 9/1/2020 at 4:52 PM an interview was conducted with LPN (licensed practical nurse) A. LPN A was asked what is the process if a CNA reports a Resident has fallen. LPN A stated, immediately the nurse assigned goes to assess, if the Resident is able to be moved after being assessed we get them out of the floor, start neuro (neurological) checks, contact the doctor and family. Everything gets entered into PCC (name of electronic charting system). On 9/1/2020 at approximately 5:00 PM an interview was conducted with LPN B. LPN B stated, definitely all falls the family needs to be notified. When asked if this is documented in the clinical record, LPN B stated, yes, we have to do proper documentation. On 9/2/2020 the facility DON provided Surveyor A with a file she identified as a soft file. The DON described soft files as, anything that is out of the norm or reported to me. Anything outside of the regular day. The DON was asked the intent or purpose of the soft files, the DON stated, for my memory so I have something to review. The DON confirmed that the soft files are kept in her office and are not part of the clinical record. The soft file for Resident #2 included a document completed by LPN C which was dated 3/14/2020. This document was an assessment following a fall but had not been placed in the clinical record. The space where LPN C would have filled out who she contacted in the family and when was blank. On 9/2/2020 at 10:43 AM an interview was conducted with LPN C. LPN C reports Resident #2 fell on [DATE] during breakfast, the CNA found her, LPN C reports going to check on Resident #2, assessing her and assisting Resident #2 to bed. LPN C further reports it is protocol to notify the family and physician following such an incident. LPN C was asked to identify in the clinical record where she recorded the family and physician notification. LPN C stated I think I failed to notify her family. On 9/2/2020 during an interview with the DON, the DON stated she expects families and the physician to be notified anytime a Resident falls and this notification to be documented in the clinical record. The DON stated she (referring to LPN C) failed to do a lot that day and we counseled her. On 9/2/2020 at 2:40 PM during an end of day meeting with the facility Administrator, DON, Assistant DON, and Corporate Clinical Director they were made aware of the findings. No further information was provided. COMPLAINT DEFICIENCY. |
| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure a Resident (Resident #2) was free from neglect in a survey sample of 3 residents. The findings included: For Resident #2, the facility staff neglected for 3 days to monitor for injuries following a fall. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/2020 was coded as an admission assessment. Resident #2 was coded as having short and long-term memory impairment. Resident #2 was coded as having required extensive assistance of staff with transfers, dressing, personal hygiene, toileting and bathing. On 9/1/2020 & 9/2/2020 during a review of the entire clinical record, to include electronic record and paper chart, it was revealed that there was no documentation of a fall that occurred on 3/14/2020 until 3/17/2020. On 9/2/2020 during a review of the paper clinical record revealed a neurological assessment flow sheet which had vital signs, level of consciousness, pupil response, and motor functioning filled in from 8:15 AM through 2:15 PM on 3/14/2020. The subsequent entries for the remainder of 3/14 through 3/17 were blank. From 3/14/2020 at 2:15 PM until 2:18 PM on 3/17/2020 there were no entries into the clinical record to indicate any assessment of or monitoring for injuries had occurred. On 3/17/2020 an entry was made at 2:19 PM that read, Resident has a N.O (new order) Ice to R (right) knee s/p (status [REDACTED]. [MEDICATION NAME] 50mg O.O (sic) q (every) 6 hours- please schedule in between [MEDICATION NAME] doses. RP made aware of above. On 3/17/2020 at 6:24 PM there was an entry made into the electronic clinical record by the Director of Nursing (DON/Employee B) that read, Administrator and writer spoke to RP /(relationship redacted) regarding fall in bathroom on Saturday 3/14/2020 and RP informed us she was not informed of the fall - we informed her we would investigate and call her of findings - spoke to assigned nurse at home, she said she did not call RP, reported (Resident #2 name redacted) was in bed and on rounds by CNA (Resident #2 name redacted) was observed in the bathroom sitting on floor in front of her wheelchair. There is also documentation in this note that the RP requested Resident #2 be sent to the hospital for evaluation. On 3/17/2020 at 9:15 PM Resident #2 was transported to the hospital, per the request of the Resident's family member. On 9/2/2020 review of the hospital records revealed in the Emergency Documentation the following: the patient presents with lower extremity pain and hip pain and deformity. Type of injury: Fall. Location: Right hip. The character of symptoms is pain and swelling. The degree at present is severe. Physical Examination: Lower extremity, the right hip shows a large hematoma and tenderness over the greater trochanter. The hospital x-ray report on 3/17/2020 at 10:46 PM revealed the following: A frontal view the (sic) pelvis reveals a [MEDICATION NAME] femoral neck. On 9/1/2020 at 4:52 PM an interview was conducted with LPN A. LPN A was asked what is the process if a CNA reports a Resident has fallen. LPN A stated, immediately the nurse assigned goes to assess, if the Resident is able to be moved after being assessed we get them out of the floor, start neuro (neurological) checks, contact the doctor and family. Everything gets entered into PCC (name of electronic charting system). On 9/2/2020 at 10:43 AM an interview was conducted |

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 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>with LPN C. LPN C stated Resident #2 fell on [DATE] during breakfast, the CNA found her, LPN C stated that they checked on Resident #2, assessed her and assisted Resident #2 to bed. LPN C stated that it is protocol to monitor Residents following a fall. On 9/2/2020 at approximately 2:30 PM the facility staff provided Surveyor A with a nurse progress note comprehensive assessment of Resident #2 which was conducted by the hospice nurse at 11:18 AM- 12:08 PM on 3/17/2020. This note was not in the clinical record of Resident #2. The assessment stated the following, Pain Status: Pain not controlled by current medication(s)/other methods. (Hospice company name redacted) CM (case manager) figured out pt (patient) states she fell at facility. Current pain value: 9 on a scale of 0 to 10. Location: knees. Intervention: New medication order obtained. New order for [MEDICATION NAME] 50 mg due to increased right knee pain post fall. Pt (patient) sat on side of bed during visit w (with) assistance. She did not want to extend R (right) leg out all the way. Pt often sits with r leg flexed while in bed. Pt seems sad on today's visit. She is not smiling and laughing out as usual. Pt w large bruise to R hand in mid stage of healing. Pt reports she was calling for assistance to go to the bathroom and no one came so she got up to go to the bathroom herself and fell . (Hospice company name redacted) CM spoke to facility nurse (name redacted) LPN, she is unaware of a fall. Facility nurse checked in computer and pt did not have bruise to hand upon admission and she did not see any documentation re: a fall as well. (Hospice company name redacted) CM spoke with DON at hospice in re to treatment for [REDACTED]. Ice to R knee ordered and [MEDICATION NAME] 50 mg po (by mouth) every 6 hours in between doses of [MEDICATION NAME] in place. (Hospice company name redacted) CM called daughter in re: to visit and she was unaware of a fall as well. She and (Hospice company name redacted) CM requesting x rays be done. Review of the facility policy titled: Recognizing Signs and Symptoms of Abuse/Neglect it stated, 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Review of the facility policy titled Abuse and Neglect - Clinical Protocol it read, The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. On 9/2/2020 the facility Administrator, DON, Assistant DON, and Corporate Clinical Director they were made aware of the findings. No further information was provided. COMPLAINT DEFICIENCY. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to follow professional standards for one Resident (Resident #2) in a survey sample of 3 residents. 1. For Resident #2 the facility staff failed to administer pain medication as ordered by the physician. 2. For Resident #2 the facility staff failed to document in the clinical record a fall. The findings included: Resident #2 was admitted to the facility on [DATE] and discharged on [DATE] to a hospital. [DIAGNOSES REDACTED]. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/2020 was coded as an admission assessment. Resident #2 was coded as having short and long-term memory impairment. Resident #2 was coded as having required extensive assistance of staff with transfers, dressing, personal hygiene, toileting and bathing. 1. For Resident #2 the facility staff failed to administer pain medication as ordered by the physician. On 9/1/2020 & 9/2/2020 during a review of the closed clinical record, review of the physician orders revealed an order on 3/13/2020 that stated, [MEDICATION NAME]-[MEDICATION NAME] Tablet 5-325 mg, give 1 tablet by mouth three times a day for pain. The Medication Administration Record [REDACTED]. Review of the nursing notes revealed the following entries: 3/14/2020 9:42 AM awaiting from pharmacy; may give when arrive. 3/14/2020 1:31 PM awaiting from pharmacy. On 9/1/2020 the facility staff provided Surveyor A with a listing of items/medications in their emergency medication box of items on hand. The listing revealed that [MEDICATION NAME]/APAP (Tylenol) 5/325 was available in the emergency box. On 9/1/2020 at 4:52 PM an interview was conducted with LPN A. LPN A was asked what is the process is if a Resident's medications are not available, LPN A stated, we can get it from Pixis (emergency medication delivery system) we call the pharmacy and get a code to get it out of there. On 9/1/2020 at approximately 5:00 PM an interview was conducted with LPN B. LPN B stated, if a medication is not available we can get meds out of Pixis, if it is not in there we would let the doctor know. The doctor may give an order for [REDACTED]. On 9/2/2020 at 12 PM an interview was conducted with the DON. The DON was asked what her expectation is of staff administering medications, I expect them to give them as ordered. When questioned if a medication is not available but is in the emergency box did she expect staff to retrieve it from there, the DON stated yes, that's what my expectation is. On 9/2/2020 at 12:30 PM an interview was conducted with LPN C and the DON. LPN C was asked if she administered the [MEDICATION NAME] to Resident #2 on 3/14/2020. LPN C stated, I see I documented on the 15th but not the 14th. In further discussion LPN C stated, I recall giving her pain meds, I remember the family brought meds. The DON retrieved the narcotic count book which revealed on 3/13/2020 the facility received 37 tablets of [MEDICATION NAME] for Resident #2. LPN C agreed, It looks like they were in the narcotic box because they were brought in on the 13th. I know my day is very busy and I get a lot of interruptions. It was an honest mistake if I didn't provide it. Review of the facility policy titled Administering Medications read, Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). According to Lippincott Manual of Nursing Practice Eighth Edition, page 18 in box 2-3 Common Legal Claims for Departure from Standards of Care lists the following: Failure to implement a physician order properly or in a timely fashion. Failure to administer medications properly and in a timely fashion. On 9/2/2020 during an end of day meeting held with the facility Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Clinical Director they were made aware of the findings. No additional information was received. 2. For Resident #2 the facility staff failed to document in the clinical record a fall. On 9/1/2020 & 9/2/2020 during a review of the entire clinical record, to include electronic record and paper chart, it was revealed that no documentation of a fall on 3/14/2020, any family or physician notification on the day of the incident. The paper chart revealed a neurological assessment flow sheet which had vital signs, level of consciousness, pupil response, and motor functioning filled in from 8:15 AM through 2:15 PM on 3/14/2020. The subsequent entries for the remainder of 3/14 through 3/17 were blank. On 3/17/2020 there was an entry made into the electronic clinical record by the Director of Nursing (DON/Employee B) that read, Administrator and writer spoke to RP /daughter regarding fall in bathroom on Saturday 3/14/2020 and RP informed us she was not informed of the fall - we informed her we would investigate and call her of findings - spoke to assigned nurse at home, she said she did not call RP, reported (Resident #2 name redacted) was in bed and on rounds by CNA (Resident #2 name redacted) was observed in the bathroom sitting on floor in front of her wheelchair. On 9/1/2020 at 4:52 PM an interview was conducted with LPN A. LPN A was asked what is the process if a CNA reports a Resident has fallen. LPN A stated, immediately the nurse assigned goes to assess, if the Resident is able to be moved after being assessed we get them out of the floor, start neuro (neurological) checks, contact the doctor and family. Everything gets entered into PCC (point click care) (name of electronic charting system). On 9/1/2020 at approximately 5:00 PM an interview was conducted with LPN B. When asked if falls are documented in the clinical record, LPN B stated, yes, we have to do proper documentation. On 9/2/2020 the facility DON provided Surveyor A with a file she identified as a soft file. The soft file for Resident #2 included a document completed by LPN C which was dated 3/14/2020. This document was an assessment following a fall but had not been placed in the clinical record. The clinical record for Resident #2 revealed no indication of her fall on 3/14/2020 until 3/17/2020 when the DON made an entry. There was no indication that the physician or the family were made aware of the fall until 3/17/2020. Review of the facility policy titled Falls- Clinical Protocol stated, The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. According to Lippincott Manual of Nursing Practice Eighth Edition, page 17 read Common Departures from the Standards of Nursing Care: Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record. On 9/2/2020 at 2:40 PM during an end of day meeting with the facility Administrator, DON, Assistant DON, and Corporate Clinical Director they were made aware of the findings. No further information was provided. COMPLAINT DEFICIENCY. |