STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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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 staff interview, clinical record review and facility document review, facility staff failed to develop a complete comprehensive care plan for one of one residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged on [DATE]. Resident #1's most recent MDS (minimum data set) assessment was a discharge assessment with an ARD (assessment reference date) of 4/21/20. Resident #1 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded in Section G (Functional Status) as needing extensive assistance from one person with bed mobility, dressing, and eating; total dependence on staff with toileting, personal hygiene, and bathing; and an 8 was coded under walking on and off the unit and locomotion on and off unit indicating that the resident did not walk or move during the seven day look back period. An 8 was also coded for transfers; indicating that Resident #1 did not transfer between surfaces (including to or from: bed, chair, wheelchair, standing position etc.) during the seven day look back period. Review of Resident #1's admission MDS with an ARD of 1/20/20, documented Resident #1 as requiring extensive assistance from two or more staff with bed mobility and transfers; and extensive assistance from one staff with locomotion on and off the unit. Resident #1 was coded as not walking during the seven day look back period. Section O of the MDS titled, Special Treatments, Procedures, and Programs revealed that Resident #1 was to receive physical therapy, occupational therapy and speech therapy services. Section V (Care Area Assessment Summary) (CAA) of the MDS; documented under triggered care area 05: ADL (activities of daily living)/rehabilitation potential, that this care area would be documented on Resident #1's care plan. Review of Resident #1's physical therapy notes revealed physical therapy was initiated on 1/14/20. Review of Resident #1's PT discharge summary dated 2/1/20 documented the following for transfer status: Transfers: inconsistent with transfers/varied from min A (minimal assist) to contact guard assist (Therapist has 1 or 2 hands on resident's body but provides no other assistance) (1) .Standing balance: Retropulsion (tendency to walk backwards) (2) causing need for CGA (contact guard assist)/UE (upper extremity) support .Distance Level Surfaces (ambulating): limited ability to consistently participate in gait training skilled interventions in this reporting period. Max distances in this reporting period: .2/1 (2/1/20) 167' (feet) with min A and front wheeled walker with increased assist due to toe walking .W/C (wheelchair mobility): Discharge 2/1/20: 100 feet Min (A) assist .Pt (patient) utilized BLE (bilateral lower extremities) with occasional BUE (bilateral upper extremities). limited ability to follow commands/sequencing related to W/C mobility training. Pt reported that he didn't want to be instructed in W/C (wheelchair) training as he just wanted to walk .Goal: Patient will safely ambulate 150 using no assistive device. Discharge: 2/1/20 Distance in feet: N/A (not applicable) Comments: Dependent .Pt (patient) and caregiver training: Instructed patient and primary caregivers in compensatory strategies, energy conservation techniques, positioning maneuvers, proper body mechanics, safety sequencing techniques, safe transfer techniques, safety precautions and use of assistive device(s) in order to increase safety and decrease need for assistance .Discharge Recommendations: may benefit from HHPT (Home Health Physical Therapy) in familiar home environment. Not clarified at this time should pt remain LTC (Long Term Care) or return home (limited support from sister, had HH (Home Health aide at PLOF (patients level of function). Review of Resident #1's comprehensive care plan dated 1/13/20 and revised 4/21/20 documented the following: The resident has an ADL self-care performance deficit r/t (related to) Dementia. Goal: The resident will improve current level of function through next review date. Interventions: Dressing: The resident will need extensive assistance of staff. Eating: The resident will need extensive assistance from staff. There was no evidence that Resident #1's care plan addressed his transfer and ambulation status. On 7/2/20 at 2:55 p.m., an interview was conducted with RN (registered nurse) #1, the unit manager. When asked if she could remember Resident #1's transfer and other mobility status, RN #1 stated that Resident #1 was dependent on staff with all ADLs. RN #1 stated that Resident #1 could transfer with staff assistance out of bed and into his chair and vice versa. RN #1 stated that she never recalled Resident #1 ever walking. When asked if ADL status should be documented on the Resident's care plan, RN #1 stated that it should. RN #1 looked at Resident #1's care plan and confirmed that only dressing and eating status were on the care plan. RN #1 stated that transfer and ambulation status were usually on the care plan. On 7/6/20 at 12:28 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked who was responsible for developing the comprehensive care plan, ASM #2 stated that herself, the ADON (Assistant Director of Nursing), the unit managers and the charge nurses were all responsible for creating and revising resident care plans. When asked if care area ADL/rehabilitation potential was triggered on a Resident's CAA (Care Area Assessment) and it was checked to be care planned, if ADL status should be documented on the resident's care plan, ASM #2 stated that it should. When asked what an ADL care plan consisted of, ASM #2 stated that an ADL care plan would include how many staff were needed to assist the resident with dressing, eating and bathing. ASM #2 stated,Stuff like that. When asked if items such as locomotion, transferring, and ambulation should be on the Resident's care plan for ADL status; ASM #2 stated that she would have to ask corporate. When asked the purpose of the care plan, ASM #2 stated that the care plan was the plan of care for each resident. When asked if staff utilize the care plan to determine a resident's needs; ASM #2 stated, Yes, they should be able to look at the care plan and know how to take care of the resident. When asked how staff would know how to take care of Resident #1; how many staff members he required for locomotion, transfers and ambulation if it was not documented on his care plan, ASM #2 stated that functional status was documented on the MDS assessments and signage is also hung over the resident's bed alerting staff of transfer status. When asked if that information should also be on the resident's care plan as well, ASM #2 stated, Yes, it probably should be. On 7/6/20 at 3:27 p.m., ASM #2, the DON (Director of Nursing) were made aware of the above findings. There was no further information provided prior to exit. Facility policy titled, A licensed nurse in coordination with the IDT (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 and maintain the highest practicable physical, mental, and psychosocial well being of the patient. (1) Contact Guard Assist-caregiver has hands on pt just incase, gives verbal cues but does not physically assist. This information was obtained from https://www.unmc.edu/patient-safety/_documents/safe-transfers-mobility-handout.pdf./ (2) Retropulsion in Parkinson ' s disease is the force that contributes to loss of balance in a backwards or posterior direction. Retropulsion occurs due to a worsening of postural stability and an associated loss of postural reflexes. This information was obtained from https://movementdisorders.ufhealth.org.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, clinical record review, and facility document review, facility staff failed to

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) ensure a discharge planning process was in place for one of one residents in the survey sample, Resident #1, that addressed his discharge needs for the use of assistive devices for locomotion while at home. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged on [DATE]. Resident #1's most recent MDS (minimum data set) assessment was a discharge assessment with an ARD (assessment reference date) of 4/21/20. Resident #1 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded in Section G (Functional Status) as needing extensive assistance from one staff member with bed mobility, dressing, and eating; total dependence on one staff member with toileting, personal hygiene, and bathing; and an 8 was coded under walking on and off the unit and locomotion on and off unit indicating that the resident did not walk during the seven day look back period. An 8 was also coded for transfers; indicating that Resident #1 did not transfer between surfaces (including to or from: bed, chair, wheelchair, standing position etc.) during the seven day look back period. Review of Resident #1's clinical record revealed an admission note dated 1/13/20 that documented the following: Resident admitted to the facility after having a fall. Resident has facial lacerations & (and) knee lacerations .resident is A/Ox 1 (Alert and Oriented to self) flat expression with confusion .resident needs to be checked on frequently r/t (related to) getting out of bed, even after patient education r/t(related to) call bell; resident found walking to the bathroom with confusion; resident is an extensive assist with transferring, bed mobility, and adl (activities of daily living) care .resident will be evaluated for PT(physical therapy). Review of Resident #1's admission MDS with an ARD of 1/20/20, documented Resident #1 as requiring extensive assistance from two or more staff with bed mobility, transfers; and extensive assistance from one staff with locomotion on and off the unit. Resident #1 was coded as not walking during the seven day look back period. Section O of the MDS titled, Special Treatments, Procedures, and Programs revealed that Resident #1 was to receive physical therapy, occupational therapy and speech therapy services. Section V (Care Area Assessment Summary) (CAA) of the MDS; documented under triggered care area 05: ADL (activities of daily living)/rehabilitation potential, that this area would be on Resident #1's care plan. Review of Resident #1's physical therapy notes revealed he was picked up from physical therapy on 1/14/20. The following was documented on his PT evaluation Reason for referral: Patient exhibits exacerbation in strength, decrease in functional mobility, decrease in transfers, reduced ability to ambulate, reduced balance and decreased neuromotor control, reduced functional activity tolerance, decreased coordination, reduced static and dynamic balance and increased need for assistance from others indicating the need for PT to evaluate need for assistive device, assess functional abilities, analyze/instruct in home exercise program, increase independence with gait, facilitate with all functional mobility, promote safety awareness, enhance rehab potential, increase awareness of environmental hazards, complete home evaluation .facilitate discharge planning. Review of Resident #1's PT discharge summary dated 2/1/20 documented the following for transfer status: Transfers: inconsistent with transfers/varied from min A (minimal assist) to contact guard assist (Therapist has 1 or 2 hands on resident's body but provides no other assistance) (1) .Standing balance: Retropulsion (tendency to walk backwards) (2) causing need for CGA (contact guard assist)/UE (upper extremity) support .Distance Level Surfaces (ambulating): limited ability to consistently participate in gait training skilled interventions in this reporting period. Max distances in this reporting period: .2/1 (2/1/20) 167' (feet) with min A and front wheeled walker with increased assist due to toe walking .Number of Stairs: 2/1/20 (discharge) 0 steps, Dependent. Comments: unable to attempt/not safe to attempt due to fluctuations in mental status and participation in this reporting period .W/C (wheelchair mobility): Discharge 2/1/20: 100 feet Min (A) assist .Pt (patient) utilized BLE (bilateral lower extremities) with occasional BUE (bilateral upper extremities). limited ability to follow commands/sequencing related to W/C mobility training .Goal: Patient will safely ambulate 150 using no assistive device .Discharge: 2/1/20 Distance in feet: N/A (not applicable) Comments: Dependent .Pt (patient) and caregiver training: Instructed patient and primary caregivers in compensatory strategies, energy conservation techniques, positioning maneuvers, proper body mechanics, safety sequencing techniques, safe transfer techniques, safety precautions and use of assistive device(s) in order to increase safety and decrease need for assistance .Discharge Recommendations: may benefit from HHPT (Home Health Physical Therapy) in familiar home environment. Not clarified at this time should pt remain LTC (Long Term Care) or return home (limited support from sister, had HH (Home Health aide at PLOF (patients level of function). Review of Resident #1's clinical record revealed that Resident #1 sustained falls while at the facility on 1/18/20, 2/5/20, 2/18/20 and 2/24/20. Resident #1 had no injuries related to the fall. Each fall was related to Resident #1 attempting to ambulate unassisted. Review of Resident #1's comprehensive care plan dated 1/13/20 and revised 4/21/20, documented the following: The resident has an ADL self-care performance deficit r/t (related to) Dementia. Goal: The resident will improve current level of function through next review date. Interventions: Dressing: The resident will need extensive assistance of staff. Eating: The resident will need extensive assistance from staff. There was no evidence that Resident #1's care plan addressed his transfer and ambulation status. Further Review of Resident #1's comprehensive care plan failed to address a discharge planning care plan. Further review of Resident #1's clinical record revealed he remained private pay until the family was able to take Resident #1 home on 4/21/20. The following discharge notes were documented by the discharge planner: 4/17/20 at 2:48 p.m.: Spoke with pt (patient) niece (Name of niece) regarding (patient) health status. Reviewed pt med (medication) list and care plan with niece, (Name of niece) verbalized understanding. 4/17/20 at 4:33 p.m.: This writer spoke with resident's niece, (Name of niece) (emergency contact #1) r/t to family's decision to d/c resident to her home (address) on Monday, 4/20/20. This writer and UM (unit manager) (Name of UM) educated (Name of niece) r/t to residents daily care, medications, ADL (activities of daily living) and his ability to walk with assistance. This writer offer assistance with home health in NC (North Carolina) and educated (Name of niece) on d/c process. Resident is scheduled to be d/c to NC on Monday, 4/20/20, family will provide transportation. Review of Resident #1's ADL tracker dated 3/1/20 through 4/21/20 revealed an 8/8 was coded under areas Walking in room and Walking in Corridor, indicating that Resident #1 had not walked during this time period. A nursing note dated 4/21/20 at 12:48 p.m. documented the following: Resident was discharge with home with his niece. Resident was picked up at 1045. Resident was taken downstairs by one CNA (certified nursing assistant) and the nurse. Discharge instructions/education provided was given to resident's RP (responsible party). All prescriptions was given to residents RP as well. All resident morning medication was given before resident left. Review of Resident's prescriptions revealed a physician's orders [REDACTED]. Review of Resident #1's Discharge Instructions/Post Discharge Plan of Care signed by Resident #1's niece and the LPN (Licensed Practical Nurse) conducting the discharge on 4/21/20, documented in part, the following: Nursing Instructions .Abilities: Uses Wheelchair . Physical Therapy: 1. Current Activity Level: 2. Physical Therapy Special Instructions: Signature Date . Nothing was documented on the discharge summary for Physical Therapy. Occupational Therapy 1. Current Activity Level: 2. Occupational Therapy Special Instructions: Signature Date . Nothing was documented on the discharge summary for Occupational Therapy. Discharge Planning Discharge to a. Home .Service Summary/Discharge Arrangements: D/C to home with home health services .Medical Equipment Arrangements .n/a (not applicable). Review of a discharge note dated 4/23/20 from the LTC ombudsman documented the following: The resident was discharged home with family and will be living in North Carolina. The family called me once the resident was home complaining that the resident could not walk and had to be carried into the home. The discharge plan noted that the resident needed a wheelchair but no arrangements were made to get the resident one to use at home. On 7/2/20 at 12:40 p.m., an interview was conducted with OSM (Other staff member) #1, the Director of Discharge Planning. OSM #1 stated that Resident #1's niece was the first emergency contact for Resident #1. OSM #1 stated that it was decided later by Resident #1's family that the niece would take Resident #1 to her home in Durham, NC with home health services. OSM #1 stated that the niece picked up the resident on 4/21/20 and that she provided transportation. When asked how Resident #1, made it down to the niece's car, OSM #1 stated that the nurse or nursing aide will bring all residents down in a wheelchair. When asked if it was discussed with the niece what durable medical equipment may be needed while at home, OSM #1 stated that she didn't think she had that discussion. OSM #1 stated that she was not sure if Resident #1 already had a personal wheelchair. When asked if Resident #1 required a wheelchair while at the nursing facility, OSM #1 stated that every patient required a wheelchair for safety. When asked what home health agency was assisting Resident #1 while at home, OSM #1 stated, I was not allowed to get that far. When asked to clarify that statement, OSM #1 stated that the family had not responded back to her regarding what home health agency they wanted to use, so she had the physician write a script for home health services so that the niece could find one under her insurance. OSM #1 stated for most discharges, she will find out that information for the family, so that home health is set up for the very next day after discharge. On 7/2/20 at 1:59 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, the nurse that discharged Resident #1. When asked how Resident #1 was brought down to his niece's car, LPN #1 stated that she brought the resident down to the lobby while he was sitting in the wheelchair. LPN #1 stated that she assisted the

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident into the car and then she couldn't remember if she took back the wheelchair or if the family took it. When asked if Resident #1 could walk with or without assistance, LPN #1 stated that she could not recall Resident #1 ever walking with a walker or with staff assistance. LPN #1 stated, From what I remember, he was total care. LPN #1 stated that Resident #1 also had a couple of falls due to him attempting to stand and walk out of his wheelchair or bed. On 7/2/20 at 2:12 p.m. further interview as conducted with OSM #1. When asked the process in determining what residents need for a safe discharge, OSM #1 stated that she provided Resident #1 with scripts for home health therapy, PT/OT etc. When asked how she determines what any resident needs for a safe discharge, OSM #1 stated that she will talk to nursing and therapy to determine needs. When asked again if Resident #1 had any assistive devices at home to help with ambulation/locomotion to assist him into his niece's residence, OSM #1 stated that she assumed he had a personal wheelchair because he had a personal health care service come to his home prior to admission into the facility. OSM #1 stated that most of the time personal health care agencies will not pick up a resident unless they have assistive devices. When asked of Resident #1 required an assistive device prior to his entry into the facility, OSM #1 stated that she did not know if he needed a wheelchair prior to facility entry. On 7/2/20 at 2:55 p.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager and the nurse mentioned in the above discharge note dated 4/17/20. When asked if she could remember Resident #1's transfer and mobility status, RN #1 stated that Resident #1 was dependent on staff with all ADLs. RN #1 stated that Resident #1 could transfer with staff assistance out of bed and into his chair and vice versa. RN #1 stated that she never recalled Resident #1 ever walking. When asked why the above discharge note dated 4/17/20 documented that she the unit manager went over with Resident #1's niece that Resident #1 could walk with assistance, RN #1 stated that she was not sure, that she never saw Resident #1 walk. RN #1 stated that she did not document that note. RN #1 stated that Resident #1 fell when he would try to stand on his own. RN #1 stated that she remembered going over the medication list and how he transferred from bed to chair, chair to chair, bathing and dressing with the resident's family. When asked if ADL status should be on the Resident's care plan, RN #1 stated that it should. RN #1 looked at Resident #1's care plan and confirmed that only dressing and eating status were on the care plan. RN #1 stated that transfer and ambulation status were usually on the care plan. On 7/2/20 at 3:21 p.m., an interview was conducted with Resident #1's niece. When asked about Resident #1's discharge, Resident #1's niece stated that facility staff had told her that Resident #1 could walk on his own but needed supervision. Resident #1s niece stated that when she got her uncle home, he could barely walk and she and a friend had to carry him into her house. Resident #1's niece stated that there was no discussion with facility staff about him needing any assistive devices such as a walker or wheelchair. Resident #1's niece stated, I didn't even think to ask about that because I was told I just needed to walk beside him. When asked if Resident #1 was using a wheelchair or walker prior to admission into the facility, Resident #1's niece stated that he was not using one then. On 7/2/20 at approximately 4:00 p.m., OSM #1 wanted to clarify her above statement with this writer. OSM #1 stated that she just looked into Resident #1's need for durable medical devices and found that because Resident #1 was walking before his entry into the facility, Medicare probably would not have covered any durable medical equipment. When asked if that would still apply if Resident#1 was not safely walking in the facility, OSM #1 stated that Resident #1 was walking in the facility. OSM #1 stated it was documented in Resident #1's fall notes that he was walking. OSM #1 then stated that everyone falls. OSM #1 then stated that she was not aware that Resident #1 needed assistive devices for ambulation/locomotion and that therapy staff are always present in every morning meeting when discharges are discussed. On 7/2/20 at 4:50 p.m., an interview was conducted with OSM (other staff member) #2, the Director of Therapy. OSM #2 read Resident #1's PT (physical therapy) notes and stated that Resident #1 not only needed a walker, but he needed a trained professional to walk with him to give him cues with ambulation. OSM #2 stated that an unskilled person would not be able to successfully walk with Resident #1 even with a walker. OSM #2 stated that due to his impaired cognition, Resident #1 could not follow one step commands or know to put one foot in front of the other. When asked if it was reasonable to expect Resident #1 to walk from his niece's car with her assistance into her home, OSM #2 stated that this was not reasonable. OSM #2 stated that because Resident #1 stayed so long in the facility after he was cut from skilled services, she did not think the therapy department was made aware of his discharge. OSM #2 stated that the therapy department is usually given a heads up on discharges. OSM #2 stated that for the longest time the therapy department was not sure if Resident #1 was going to stay in the facility LTC or be discharged home. OSM #2 stated that she knew there was a lot of back and forth with Resident #1's family. On 7/6/20 at 1:41 p.m., an interview was conducted with OSM #3, the long term care ombudsman. OSM #3 stated that he could not recall facility staff discussing Resident #1's need for assistive devices. OSM #3 stated that he had received a call from the niece when she returned home with Resident #1 saying that she was told by facility staff that Resident #1 was able to walk but had found out that he could barely walk. OSM #3 recalled the niece stating that she and a friend had to carry Resident #1 from the car into her house. OSM #3 stated that he referred the family to the appropriate state agency. On 7/6/20 at 3:27 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above findings. Complaint deficiency. Facility Policy titled, Discharge Planning will be initiated and coordinated by the discharge planner who will assist the patient/family to make arrangements for transportation, care equipment, home health services, etc. (Discharge planning and/or therapy will take responsibility for completion of any or all arrangements). Facility Policy titled, Discharge Planning Policies and Procedures documented in part, the following: Discharge planning staff will initiate the discharge Instructions in PCC (Point Click Care) no later than 48 hours prior to a scheduled discharge from the center and immediately notify the IDT (Interdisciplinary Team) that the assessment is available for completion .monitor to confirm timely and efficient completion by all departments prior to the patients scheduled discharge .Once the form is completed and signed by all disciplines (PT, OT, ST, Nursing, and Dietary), the discharge instructions must be locked by Discharge Planning. (1) Contact Guard Assist-caregiver has hands on pt just incase, gives verbal cues but does not physically assist. This information was obtained from https://www.unmc.edu/patient-safety/_documents/safe-transfers-mobility-handout.pdf./ (2) Retropulsion in Parkinson ' s disease is the force that contributes to loss of balance in a backwards or posterior direction. Retropulsion occurs due to a worsening of postural stability and an associated loss of postural reflexes. This information was obtained from https://movementdisorders.ufhealth.org.