STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING ______ B. WING ______	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 9/10/19 through 9/11/19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this sixty certified bed facility was 57 at the time of the survey. The survey sample consisted of one closed record review (Resident #1).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and complaint investigation, the facility staff failed to assess one of one resident in survey sample, following a witnessed accident. Facility staff witnessed Resident #1 twist her foot under her wheelchair and voice pain at the time of the incident. There was no assessment of Resident #1's foot or ankle by facility staff following the incident. The findings include:	F 684	Past noncompliance: no plan of correction required.	9/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/30/2019

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 684	Continued From page 1 Resident #1 was admitted to the facility on 8/7/19 and was discharged on 8/16/19. Diagnoses for Resident #1 included post-surgical care for femur fracture revision, cognitive communication disorder, heart failure, morbid obesity, diabetes, diabetic neuropathy, acute kidney failure, depression and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 8/14/19 assessed Resident #1 as cognitively intact. Resident #1's closed record was reviewed while investigating complaint allegations regarding an injury to the resident's left foot/ankle. The record documented a physical therapy (PT) note dated 8/16/19 stating, "Pt [patient] was seen for a limited tx [treatment] session as she was reportedly up all night...just went to bed after breakfast...She later participated with PT but only to perform seated there ex [therapy exercises] due to straining her ankle immediately prior to PT with pt leaving facility after lunch for an appointment..." This note documented the resident performed hip isometrics (squeezing ball between knees) and seated strength exercises with the right leg only during this session. Therapy records documented the resident was treated by PT on 8/16/19 from 12:40 p.m. to 1:00 p.m. Facility sign out sheets documented the resident left the facility on 8/16/19 at 1:45 p.m. accompanied by her spouse. Prior to Resident #1 signing out of the facility on 8/16/19 at 1:45 p.m., the clinical record documented no assessment or any mention of an incident related to the ankle strain referenced in the PT note.	F 684		

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A nursing note dated 8/16/19 at 3:41 p.m. documented a phone call was received from an outside provider regarding an injury to Resident #1's left ankle. This note documented, "Rec'd phone call from [primary care provider] regarding resident that was being seen in her office for medication assistance with Medicaid services. While there, resident complained of left ankle pain and reported 'foot getting ran over while in the w/c [wheelchair].' [Primary care provider] reported that she did evaluate left ankle and noted some swelling in the left lateral malleolus region. Writer explained that resident had swelling evaluated here at the facility by the practitioner and ordered a US [ultrasound] which was completed and no DVT [deep vein thrombosis] identified. Nurse reported that resident signed out from the facility... [Primary care provider]...recommended evaluation from ED [emergency department]. Facility contacted ED and informed of above and verified resident was being seen in ED at this time..."

The primary care provider's (other staff #4) note dated 8/16/19 documented she was asked by her staff to assess Resident #1's foot/ankle while the resident was in the office on 8/16/19 due to appearance of the leg and the resident's complaint of pain. The primary care provider's documentation dated 8/16/19 stated, "...Leg noted to be red, swollen, tender...Pt in obvious pain...Patient reported nursing home staff pushed her to PT in wheelchair w/o [without] foot rests, foot fell to floor, went under seat + twisted. Pt complained of pain/injury...I noted swelling to lateral/posterior malleolus [ankle] as well as diffusely on knee. Leg painful to touch in those areas. I sent her to the ER [emergency room]..."

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F 684	Continued From page 3 Resident #1's hospital emergency room report dated 8/16/19 documented the resident presented with complaints of left lower leg pain and reported that her foot got caught under the wheelchair at the nursing facility earlier in the day. This report documented the resident's left foot was assessed with, "...moderate edema over the lateral malleolus and proximal dorsal foot...Severe tenderness...over the lateral malleolus. No palpable deformity or crepitus but examination is limited due to pain..." X-ray documented the resident was diagnosed with a "mildly angulated fracture of the distal shaft of the fibula with buckling of the cortex. There is probably a minimal amount of medial subluxation [partial dislocation] of the distal tibia. There may also be a nondisplaced fracture of the posterior malleolus..." The resident was splinted and referred to orthopedics for further treatment. On 9/10/19 at 11:45 a.m., Resident #1 was interviewed about her left ankle injury. Resident #1 stated on 8/16/19, a therapy employee took her from her room to the therapy department in a wheelchair without footrests. Resident #1 stated her left foot caught on the floor during transport, twisting her left foot under the wheelchair seat. Resident #1 stated she screamed out in pain when her foot was caught under the chair. Resident #1 stated the therapist took her to the therapy room and applied ice. Resident #1 stated she left the facility a short time after therapy for an appointment at her primary care provider. Resident #1 stated by the time she got to the primary care provider's office, the left ankle "ballooned out" and was red. Resident #1 stated she was sent to the emergency room from the provider's office and was later diagnosed with a fractured ankle.	F 684		

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On 9/10/19 at 1:00 p.m., the occupational therapist (OT) with Resident #1 at the time of the injury on 8/16/19 was interviewed. The OT stated Resident #1 was self-propelling in the wheelchair when her left foot caught on the floor and twisted under the wheelchair seat. The OT stated he and a therapy student accompanied Resident #1 from her room to the therapy department at the time of the incident, walking behind the wheelchair as the resident self-propelled. The OT stated the resident "hollered out" at the time of incident stating her left leg/foot hurt. The OT stated he then put a leg rest on the wheelchair and took her to the therapy department. The OT stated he applied an ice pack to the resident's left ankle and notified the physical therapist (PT). The OT stated the resident said she was "hurting and sore" but the resident was not crying. The OT stated he did not report the incident/injury to nursing and in retrospect, he should have reported the incident. The OT described the resident as "very emotional" and he did not think the injury/incident was significant. The OT stated there was no documented assessment of the resident after the incident and he did not document the incident in the therapy notes. The OT stated, "I didn't think it was a serious issue." The OT stated the ice was removed from the ankle before the resident left the therapy department and the resident left the facility shortly after for an appointment.

On 9/10/19 at 1:45 p.m., the licensed practical nurse (LPN #1) caring for Resident #1 on 8/16/19 was interviewed. LPN #1 stated the resident routinely self-propelled in her wheelchair in her room and throughout the building. LPN #1 stated she had no knowledge of any incident with the

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wheelchair or the left ankle injury on 8/16/19 until the primary care provider's office called later in the afternoon stating the resident was sent to the emergency room. LPN #1 stated therapy reported nothing to her about an injury or incident.

On 9/10/19 at 2:00 p.m., the unit manager (LPN #2) caring for Resident #1 was interviewed about the incident on 8/16/19. LPN #2 stated, "Nobody told me about the incident." LPN #2 stated she was not aware of an incident and/or injury until the resident's primary care provider called later in the afternoon on 8/16/19 and informed her the resident was sent to the emergency room.

On 9/10/10 at 3:30 p.m., the physical therapist (PT) that treated Resident #1 on 8/16/19 was interviewed. The PT stated OT reported to her the resident had caught her left foot under the wheelchair while coming to the therapy department. The PT stated ice had been applied to the left ankle prior to her therapy session with the resident. The PT stated the therapy exercises were done only with the right leg that day due to the iced ankle. The PT stated the resident took the ice pack off the left ankle shortly before her session ended. The PT stated she "really didn't look at it [left ankle]." The PT stated she referenced the injury in her note of 8/16/19 because of the abbreviated therapy performed but did not report the injury to nursing.

Resident #1's clinical record documented a PT evaluation dated 8/8/19 stating the resident required no assistance with wheelchair mobility and listed the resident as "independent" with wheeling the wheelchair distances equal to or greater than 150 feet. Nursing notes during the resident's stay documented the resident required

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one person physical assistance with transfers and set up help only with bed mobility, eating and toilet use.

Resident #1's plan of care (revised 8/12/19) documented the resident had altered musculoskeletal status and potential for falls/pain due to left femur surgical repair status. Interventions regarding pain and fall prevention included resident education on fall prevention and use of safety devices, non-slip footwear, use of wheelchair for mobility and assessment of verbal and non-verbal signs of pain (grimacing, crying, moaning, increased anxiety).

The facility's policy titled Resident Safety (revised April 2019) documented on page 2, "An Incident Report will also be completed...if a resident is involved...A Quick Response will be completed ...within twenty-four (24) hours of the following events/incidents...Injury of Known/Unknown Origin..."

These findings were reviewed with the administrator and director of nursing on 9/11/19 at 10:15 a.m.

This was a complaint deficiency.