STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING ______ B. WING ______	C 11/21/2019

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/19/19 through 11/21/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 3 complaints were investigated during the survey. The census in this 90 certified bed facility was 81 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Resident #1 and Resident #2) and 1 closed record review (Residents #3).	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		1/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/10/2019

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 655	Continued From page 1 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on a medical record review, staff interviews and facility document review, the facility staff failed to develop and implement a Baseline Care Plan within 48 hours of admission for 1 of 3 residents in the survey sample, Resident #3. The findings included: Resident #3 was admitted on 12/6/18 with diagnoses to include Left Hip Replacement and Dementia. On 11/20/19 Resident #3's closed record was reviewed and a baseline care plan was not found. The facility Nurse Consultant was asked if she could locate Resident #3's baseline care plan that	F 655	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F655	

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F 655	Continued From page 2 was completed within 48 hours of admission. On 11/20/19 at approximately 3:30 P.M. the Nurses Consultant stated, "I cannot find the baseline care plan it does not appear that it was done." The facility policy titled "Care Planning" effective date 11/01/19 was reviewed and is documented in part, as follows: Policy: A licensed nurse, in coordination with the 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 or maintain the highest practical physical, mental, and psychosocial well-being of the patient. Procedure: 1. The computerized baseline Care Plan is initiated and activated within 48 hours. On 11/21/19 at 1:45 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Nurse Consultant where the above information was shared. The Director of Nursing was asked what was her expectation for the baseline care plan. The Director of Nursing stated, "I expected for it to be completed with 48 hours of admission because it directs the care of the resident." Prior to exit no further information was shared.	F 655	1-Resident #3 was discharged on 12/ 19 /18. 2- The DON or designee will review residents admitted in the past 30 days to ensure that a baseline care plan was completed within 48 hours of admission. 3- The DON or designee will educate Nurses on the policy and procedure for completing baseline care plans for residents admitted to the facility within 48 hours of admission. 4-The Unit manager or designee will review residents admitted to the facility on a weekly basis to ensure that the baseline care plan was completed within 48 hours of admission. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 1/2/20.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		1/2/20

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F 657	Continued From page 3 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility failed to ensure 1 of 3 residents in the survey sample, Resident #1's, Comprehensive Person Centered Plan of Care was revised to include fall interventions following an avoidable fall from the bed during the provision of care that required emergency room evaluation. The findings included: Resident #1 was originally admitted to the facility	F 657	F657 1-The care plan for resident #1 was revised to include interventions implemented after the most recent fall that occurred on 11/1/19. 2- The DON or designee will review the care plan after any resident falls that occurred in the past 30 days to ensure that the interventions implemented after a	

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F 657	Continued From page 4 on 1/24/11 with a re-admission date of 9/4/18 with diagnoses to include but not limited to, coronary artery disease, high blood pressure and diabetes type II. The current Minimum Data Set (MDS) an annual, with an assessment reference date of 9/10/19, coded the resident as scoring a 10 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The resident was coded as requiring extensive assistance of one staff for bed mobility, transfers and toileting. The resident was wheelchair bound. Review of the clinical record and a facility investigation evidenced on 11/1/19 at approximately 4:25 a.m., Certified Nurse Assistant (CNA #2) went into the resident's room to provide incontinent care. The resident was not placed in the proper position, but instead was positioned more to the edge of the bed and when the CNA turned the resident to the right side the resident fell to the floor. The resident was sent to the emergency room for evaluation and treatment. The resident was diagnosed with the following: forehead abrasion and adult head injury to include concussion (a jarring injury to the brain), contusion (a bruise of the brain, bleeding in the brain that can cause swelling) and hematoma (bleeding in the brain that collects, clots, and forms a bump); definitions obtained from the ER discharge instruction sheets. On 11/21/19 at 11:11 a.m., the Director of Nursing (DON) was interviewed. In response to the fall she wrote a Performance Improvement Project that included in part: Updating the care plan to include interventions after the incident for	F 657	fall are added to the care plan in a timely manner. 3-The DON or designee will educate Nurses on the policy and procedure for timely revising care plans with interventions implemented after a resident fall. 4-The DON or designee will review the care plan on a weekly basis after a resident fall to ensure that the care plan was updated with interventions implemented after a fall. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 1/2/20.	

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F 657	Continued From page 5	F 657		

two person assist for care, and a sign to be posted in this resident and any other resident room to indicate those needing two person assist with care.

Review of the Comprehensive Person Centered Plan of Care on 11/19/19, 11/20/19 and 11/21/19 prior to exit, failed to evidence it was revised to include two person for bed mobility, incontinent care and also did not include posting of the two person sign above the head of the bed. The care plan did identify the resident had and ADL self-care performance deficit related to cognitive loss and included in the interventions that the resident was a two person assist with transfers.

Review of the Visual/ Bedside Kardex Report on 11/21/19 for the CNA's that included care plan interventions, failed to include a revision that the resident was a two person assist during bed mobility, transfers, incontinent care and the posting of the sign above the head of the bed.

On 11/19/19 at 12:45 p.m., the resident was sitting at the bedside in a wheelchair. A large Band-Aid was observed to the resident's left forehead. The resident was asked about the fall, and she stated she fell from the bed. When asked how it happened she stated she did not want to get anybody in trouble and did not comment any further about the fall incident. A sign was posted above the bed with a picture of two individuals.

The above findings was shared with the Administrator, the Director of Nursing and the Nurse Consultant during a pre-exit meeting on 11/21/19. The Director of Nursing was asked about the failure to revise the care plan following

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F 657	Continued From page 6 the fall. She stated she would have expected the care plan to have been revised within twenty-fours of the event. Shortly after the pre-exit meeting the Director of Nursing brought in an updated copy of the Comprehensive Person Centered Plan of Care and Kardex with revisions for the fall dated 11/21/19. The facility policy dated 11/1/19 titled Resident Assessment & Care Planning reads in part: Policy: A licensed nurse, in coordination with the interdisciplinary team, develop 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 or maintain the highest practical physical, mental, and psychological well-being of the patient. Procedure: 6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. The Nursing Policy dated 11/1/19 titled Falls Management Program read, in part: 4. A licensed nurse will review, revise and implement interventions to the care plan based on: a. Post Fall Assessment findings. Complaint Deficiency.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		1/2/20

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F 689 Continued From page 7

The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, clinical record review, facility document review, and during the course of a complaint investigation, the facility failed to ensure 1 of 3 residents in the survey sample (Resident #1) was free from an avoidable fall from the bed during the provision of care that required emergency room evaluation with subsequent head injury resulting in harm.

The Certified Nursing Assistant (CNA #2) failed to ensure Resident #1 was not too close to the edge of the bed prior to repositioning; as a result, the resident fell out of the bed, which was in a high position, onto the floor. The resident sustained a head injury, a deep contusion and abrasion to the right forehead. After the fall the resident was fearful upon repositioning and suffered with ongoing headaches.

The findings included:

Resident #1 was originally admitted to the facility on 1/24/11 and had a re-admission date of 9/4/18 with diagnoses to include but not limited to, coronary artery disease, high blood pressure and diabetes type II.

The current Minimum Data Set, an annual, with an assessment reference date of 9/10/19 coded the resident as scoring a 10 out of a possible 15

F 689

F689

1-Resident #1 has not had any falls since 11/1/19. The CNA involved in the incident received verbal counseling and re-education on proper bed positioning when providing care in the bed for a resident on 11/ 1 /19 by the DON.

2-All residents are at risk for falls during the provision of care. The DON or designee will observe each CNA to ensure that safety measures are followed during provision of care for residents while in the bed.

3-The DON or designee will educate the Nurses and CNA□s on appropriate safety measures to take when providing care for the residents when in bed to prevent falls.

4-The Unit Manager or designee will complete random weekly observations of CNA staff providing care for residents when in the bed to ensure that they are providing appropriate safety measures to

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F 689	Continued From page 8 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The resident was coded as requiring extensive assistance of one staff for bed mobility, transfers and toileting. The resident was wheelchair bound. The complainant alleged the resident was pushed out of the bed and sustained injuries to the forehead and a concussion on 11/1/19. Review of the clinical record and a facility investigation evidenced on 11/1/19 at approximately 4:25 a.m., CNA #2 went into the resident's room to provide incontinent care. The resident was not placed in the proper position, instead was positioned more to the edge of the bed and when the CNA turned the resident to the right side the resident fell to the floor. The nurse documented, "This nurse was called to resident's room. C.N.A stated, "she fell while I was changing her. Upon entering resident noted face down on floor with head bleeding profusely." The nurse instructed the CNA to apply pressure to the open area to the resident's left forehead, called the nurse practitioner and received orders to send the resident to the emergency room for evaluation and treatment. 911 was called and transported the resident to the local emergency room. The Emergency Room Physician notes dated 11/1/19 read, in part: "The patient sustained injury to the head, contusion, pain, swelling. Head/face: Noted is contusion, that is deep, a lacerations(s), that is superficial. A CT scan was completed, initial encounter blunt trauma (contusions or hematomas) and concussion / head injury. The CT scan was negative for fractures. The resident was diagnosed with a cephalohematoma (a mass	F 689	avoid falling out of the bed. The DON will review resident fall investigations to ensure that appropriate safety measures were followed during the provision of care when in bed. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 1/2/20.	

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F 689	Continued From page 9	F 689		

composed of clotted blood, located between the periosteum and the skull secondary to rupture of blood vessels-referenced from Taber's Cyclopedic Medical Dictionary, 19th Edition.). The resident was treated with one dose of an antibiotic (Keflex) and Bacitracin ointment was applied to the forehead abrasion. The resident was sent back to the facility with discharge instructions for the treatment and monitoring of the forehead abrasion and adult head injury to include concussion (a jarring injury to the brain), contusion (a bruise of the brain, bleeding in the brain that can cause swelling) and hematoma (bleeding in the brain that collects, clots and forms a bump)" The definitions were obtained from the ER discharge instruction sheets. The head injury sheet read, in part: After injuries such as yours, most problems occur within the first 24 hours, but side effects may occur up to 7-10 days after the injury. It is important for you to carefully monitor your condition and contact your health provider or seek immediate medical care if there is a change in your condition. Other causes of major head injuries include bicycle or motorcycle accidents, sports injuries, and falls.

On 11/19/19 at 12:30 p.m., the Administrator was interviewed. She was asked about the avoidable fall. She stated, "When she was repositioned with the sheet that was under her, she flipped, her weight was not distributed evenly...she went off the bed."

CNA #2 was interviewed on 11/21/19 at 2:30 p.m. When asked about the resident's fall he stated, "I went to do ADL (activities of living-incontinent care), I turned her and her legs went over, when I tried to pull her over her top half went over then her whole body went down to the floor...I had the

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F 689	Continued From page 10 bed elevated all the way up." He stated the Director of Nursing called him in later that day to do a one to one inservice on proper bed repositioning technique. He stated he did not have the resident closest to him and not near the middle of the bed and stated "It was poor thinking" on his part as to why the avoidable fall occurred. CNA #4 was interviewed on 11/21/19 at 11:00 a.m. She was asked about the resident's bed mobility and a sign that was posted above the resident's bed that had a picture of two figures. She stated, "Two person, that started from the fall...two people need to be in there, for bed mobility, incontinent care, transfers..." She stated that the resident was very fearful after she fell from the bed with repositioning but has gotten better and needs to be talked to calmly during repositioning. Review of the Visual/ Bedside Kardex Report for the CNA's that included care plan interventions failed to include that the resident was a two person assist during bed mobility, transfers, incontinent care and the posting of the sign above the head of the bed. The Person Centered Plan of Care also failed to evidence it was revised to include the two person bed mobility, two person incontinent care, or the two person assist sign. The physician orders dated 11/1/19 after the resident returned to the facility from the Emergency Room were to administer Tylenol Extra Strength tablet 500 milligrams two tablets every 12 hours for pain for 14 doses (last dose 11/8/19). The Medication Administration Record evidenced after the 14 days the resident continued to complain of headaches and was	F 689		

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F 689	Continued From page 11	F 689		

administered as needed Tylenol 325 milligrams two tablets on 11/11/19 and 11/17/19. The treatment order for the forehead wound was to cleanse with soap and water, apply bacitracin and a xeroform emulsion dressing every day shift until 11/5/19. A second order dated 11/5/19 was to clean the facial wound with soap and water, apply bacitracin and cover with a Band-Aid daily until 11/14/19. The resident's vital signs and neurological checks were conducted every four hours for four days.

On 11/19/19 at 12:45 p.m., the resident was sitting at the bedside in a wheelchair. A large Band-Aid was observed to the resident's left forehead. The resident was asked about the fall, and stated she fell from the bed. When asked how it happened she stated she did not want to get anybody in trouble and did not comment any further about the fall incident. When asked if she was having any pain, she stated "Yes" and pointed to her bandaged left forehead. A sign was posted above the bed with a picture of two individuals. At 1:30 p.m., the resident was still sitting at the bedside in the wheelchair. She was asked if she was still having pain and stated "Yes," she rated the pain to her head a 7 out of a possible 10; 10 being the worst pain.

On 11/20/19 at 3:39 p.m., CNA #11 who was assigned to care for the resident was interviewed. She was asked what the sign above Resident #1's bed was. She stated, "Anything to do with transfers is two people." The CNA was asked about incontinent care for the resident while the resident was in bed how many staff would it take, she stated "One person." The CNA stated she attended the Inservice for the two-person sign provided by the unit manager. The sign in sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING ______ B. WING ______	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND HEALTH & REHABILITATION CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

(with no date) had CNA #11's signature.

On 11/21/19 at 11:11 a.m., the Director of Nursing (DON) was interviewed. The DON was asked based on the facility's investigation of the fall what did the facility determine was the cause of the resident falling from the bed during care. She stated the CNA "Misjudged the positioning" of the resident and should have had the resident closer to him. She stated the resident was, "Too close to the edge of the bed...she was not positioned in the bed correctly." In response to the fall she provided one to one education to the CNA, an agency employee, implemented a sign above the resident's bed indicating the resident was a two person assist with bed mobility and care to include incontinent care in bed and all transfers. She stated the daughter was angry and she was the one who suggested two staff attend to the resident during bed mobility and during the provision of care. The DON further stated staff were to be inserviced on safe handling of residents in the bed, this training was started on 11/15/19. She stated that she was also going to schedule the training in their computer based education program "Name." When asked about the resident's injuries, she stated, "Her eye was swollen shut, it looked really bad."

On 11/21/19 at 2:10 p.m., the dressing to the resident's left forehead was changed by Licensed Practical Nurse #10. The hematoma to the left forehead was approximately 3 centimeters by 3 centimeters, it stuck out approximately 1/2 an inch with an open area in the center with dark tissue measuring approximately 1/2 centimeter in diameter. The resident winced when the nurse cleansed the wound and applied the top dressing. The resident was asked if she had any pain when

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the nurse was cleaning the wound, she stated she experienced "discomfort."

On 11/21/19 at 2:50 p.m., the Nurse Practitioner was interviewed. She stated she was called on the early morning of 11/1/19 and was notified the resident had fallen out of the bed and was bleeding from her forehead. She gave the order to send the resident to the Emergency Room. She stated the resident sustained, "A pretty significant head injury."

The above findings was shared with the Administrator, the Director of Nursing and the Nurse Consultant during a pre-exit meeting on 11/21/19. Following the pre-exit meeting the facility was provided ample opportunity to bring forward any other documents or information. No additional information was provided to the survey team prior to exit.

Complaint Deficiency.