STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(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
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite 2/23/21 and continued offsite on 2/24/21. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. The census in this 180 certified bed facility was 114 at the time of survey. Since the start of the pandemic a total of 58 residents had tested positive for COVID-19 with a total of 51 resident recoveries. Since the start of the pandemic a total of 25 staff had tested positive for COVID-19 with a total of 25 resident recoveries. There had been 5 resident deaths related to COVID-19. The survey sample consisted of one closed record review; Resident #1 and four current record reviews; Resident #2 through #5.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 2/23/21 and continued offsite on 2/24/21. One complaint was investigated: VA00050784 was Substantiated with deficiencies. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 180 certified bed facility was 114 at the time of survey. Since the start of the pandemic a total of 58 residents had tested positive for COVID-19 with a total of 51 resident recoveries. Since the start of the pandemic a total of 25 staff had tested positive for COVID-19 with	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/01/2021

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 000	Continued From page 1 a total of 25 resident recoveries. There had been 5 resident deaths related to COVID-19. The survey sample consisted of one closed record review; Resident #1 and four current record reviews; Resident #2 through #5.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		3/1/21

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F 609	Continued From page 2 Based on staff interview, facility document review and clinical record review it was determined that facility staff failed to report an allegation of sexual abuse reported to administration on 2/3/21; AND an injury of unknown origin obtained on 2/2/21 in a timely manner to the appropriate state agencies for one of 5 sampled residents, Resident #1. The findings included: 1. Resident #1 was admitted to the facility on 1/12/21 with diagnoses that included but were not limited to unspecified convulsions, vascular dementia without behavioral disturbance, history of TIA (stroke), retention of urine, type two diabetes mellitus, and muscle weakness. Resident #1's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date of 1/18/21. Resident #1 was coded as being severely impaired in cognitive function scoring 06 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #1 was coded as requiring extensive assistance with two staff members with bed mobility, and transfers, and extensive assistance from one staff with dressing, eating, and personal hygiene, and total dependence on one staff member with toileting. Review of Resident #1's clinical record revealed that Resident #1 had a laceration of unknown origin on 2/2/21, 11-7 shift. The following note was documented: "Was notified by CNA (Certified Nursing Assistant) about resident laying in bed with laceration to the forehead, it was also noted that Foley (catheter) was pulled out of patient and laying on the floor. Resident could not verbalize what happened and how injury occur. Upon a full head to toe assessment, resident had 3.0 x 0.5	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 3 laceration on the upper left side of eyebrow. No other visible injuries present at this time. Laceration was cleaned with Darkins (sic) and sterile strips applied. 18 Fr (French) Foley was reinserted and hematuria (blood in urine) observe. primary care provider (Name) and family (Name of Son, Next of Kin) made aware about incident. Risk management completed, post assessment completed, and incident report completed. Neuro checks initiated and residents vital signs are within normal limits. Resident care plan has been updated and patient is on continues rounding. Resident does not show any signs or pain or discomfort at this time. Bed in lowest position and call bell within reach. will continue to monitor resident." Review of Resident's #1's Urology appointment summary dated 2/2/21 documented in part, the following: "...presents in office today with head wound due to fall at rehab center, Wound is bleeding and has one butterfly closure. Pt (patient) denies head pain." Review of Emergency room notes dated 2/2/21 documented in part, the following: "75 yo (year old) female with history of...vascular dementia, presents for evaluation after fall this morning. Foley catheter became dislodged during fall, though pt was taken to Urology clinic...Pt noted to be at baseline mental status. Laceration noted to left forehead. On exam. pt awake and alert...Laceration noted to left forehead without active bleeding...Nursing staff notes pt's son reports she (Resident #1) is concerned for possibility of sexual assault at nursing facility. Son is not sure if pt's dementia is playing into these concerns, related to Foley catheter care today...discussed options for patient's son,	F 609		

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F 609	Continued From page 4 including police report and possible SANE (Sexual Assault Nurse Exam). Patient's son has spoke with his sister, patient's daughter, who is a police officer and decided they will take patient home without further action in the ED (Emergency Department). A note from the social worker dated 2/3/21 documented in part, the following at 3:16 p.m.: "Resident's daughter, (Name) visited the facility today demanding to speak with Nursing Management and this writer. Per daughter, resident stated that she (Resident #1) was raped in the facility, but daughter stated," I don't believe that, I know my mom has confusion..." Review of a FRI (Facility Reported Incident) from the facility administrator) documented in part, the following: "Report Date: 2/4/21; Incident Date: 2/1/21; Allegation of abuse/mistreat...Pt's daughter reported potential sexual abuse by male staff member prior to discharge...Name of employees: unknown- (Name of RN #1) was the nurse on duty...investigation is underway...2/4/21: To whom it may concern...On February 4th at approximately 4 p.m. this write (sic) was made aware of a sexual assault allegation. The writer was informed of the allegation of a patient, (Name of Resident #1), by one of the facility's male nurses. The allegation was reported by the patient's daughter (Name of daughter). The daughter reported that the patient stated she was sexually assaulted while at the facility. The patient discharged from this facility on February 2nd. The patient is currently residing at home with her family. Of note, the patient had to have her Foley catheter reinserted, by a male nurse, after she sustained a fall the night before discharge. (Name of Resident #1's daughter) did state that	F 609		

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F 609	Continued From page 5 this reinsertion of the Foley catheter could be the root cause of the allegation. The police have been notified and the results of the investigation will be submitted no later than 2/11/21. Review of the fax confirmation for the initial FRI revealed that it was sent to the appropriate state agencies on 2/4/21 at 5:30 p.m. Review of a witness statement from the male nurse who worked 2/2/21 11-7 shift documented the following: "I started my shift at 11 pm, took report and did my regular rounding on all patient (sic). I saw (Name of Resident #1) laying in bed with head of bed elevated, no distress or pain noted. At about 4:45 a.m., CNA came to nurses station and notified the writer of this statement that (Name of Resident #1) was bleeding from the forehead and her Foley was pulled out...I with the CNA went to the resident's room, resident was seen in bed with a laceration to forehead...resident could not verbalize what had occurred...With CNA present in room I performed a head to toe assessment. Resident had a 3.0 x 0.5 laceration of the left eyebrow and resident's Foley was pulled out and laying on the floor. No other visible injuries were observed on resident. Resident's laceration was cleaned with Darkins (sic) and sterile (sic) strips applied to laceration. With CNA present in room, I informed resident of replacement of removed Foley. A new 18 Fr Foley was reinserted, upon reinsertion, hematuria was noticed. Primary care (Name of physician), ADON (Assistant Director of Nursing) and Family (Name of son) was notified about incident..." Review of a witness statement from CNA #1, the CNA present on 2/2/21; documented in part, the following: "I saw her first a little before	F 609		

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F 609	Continued From page 6 midnight...she was fine...I saw her again at about 2:15 a.m...she was clean and dry...I looked in room at 3:45 a.m....she was still fine. I came in the room at about 5:30 AM doing my second rounds, her night shift and brief were on the floor in between the two beds...I grabbed clean sheets and a clean gown. I came back in an cleaned her bottom and back side and put clean gown and brief on her right side...I saw the Foley was out on the floor. I didn't want to leave her half nude so I went around to put the other side of the gown on. When I turned her I saw the cut on her forehead. I fastened her brief, put her gown on the left arm and went directly to notify the nurse...Nurse gathered supplies for Foley catheter. He informed me that once he was ready, we both went into room together and stayed in the room together while catheter was inserted..." On 2/4/21 at 11:57 a.m., an interview was conducted with OSM (Other Staff Member) #3, the Director of Social Services. When asked about her above note dated 2/3/21 documenting that Resident #1's daughter stated that her mother alleged that she was raped in the facility, OSM #3 stated that the daughter had come into the facility on 2/3/21 and had made the above statement. OSM #3 also stated that the daughter didn't believe her mother; that her mother had a history of making previous rape allegations in the past. When asked where she documented that the resident had a previous history of making rape allegations; OSM #3 stated that she wouldn't document something like that if it didn't occur in the facility. When asked who she reported this allegation to after her discussion with the daughter, OSM #3 stated that she reports in a meeting everyday. When asked who attends the meeting, OSM #3 stated that she told "the team."	F 609		

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F 609	Continued From page 7 When asked who specifically she alerted regarding this allegation of "rape," OSM #3 stated that she alerted the DON and ADON but she couldn't say if it was immediately. OSM #3 stated that that she knew it was that day (2/3/21) because she didn't go home with that information and not tell anyone. When asked who the abuse coordinator was, OSM #3 stated that the facility did not have one. OSM #3 then stated that she knew a psychologist came to the building. When asked if an allegation of abuse should be reported immediately, OSM #3 stated, "If an allegation is made. Absolutely." When asked why she didn't report this allegation immediately and document when and who she reported to; OSM #3 stated, "The daughter clearly stated she didn't believe it and knows her mother better than anyone." When asked if an allegation of rape made by a resident should be considered an allegation of abuse even if the resident's family did not believe the allegation occurred, OSM #3 stated, "I can't go along with that." On 2/4/21 at 12: 47 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing). When asked when they were made aware of the allegation of rape that Resident #1's daughter had reported to the facility social worker, ASM #2 stated that the daughter had come into the facility on 2/3/21 and that the social worker had made them aware. ASM #2 stated that there was so much going on that she could not remember when OSM #3 had made them aware. When asked when an allegation of sexual abuse should be reported, ASM #2 stated that an allegation of abuse should be reported within 2 hours and an investigation should be initiated immediately. When asked if the DON	F 609		

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F 609	Continued From page 8 and ADON were made aware on 2/3/21 if a facility FRI should have been sent then, rather than 2/4/21 the next day; ASM #2 stated that it should have. ASM #2 then stated that ASM #1, the facility Administrator was also made aware on 2/3/21. On 2/4/21 at 12:48 p.m., an interview was conducted with ASM #1, the facility Administrator. ASM #1 stated that he was made aware on 2/3/21 that the daughter had come into the facility expressing concerns with one of them being that her mom claimed to be raped. ASM #1 stated that from his understanding; the daughter really didn't believe this had happened. ASM #1 stated that he called the daughter the next day on 2/4/21 to follow up with her concerns. ASM #1 stated a FRI was submitted after his conversation with the daughter on 2/4/21. When asked when allegations of abuse should be reported, ASM #1 stated that allegation of abuse should be reported within 2 hours. When asked if all allegations of abuse should be investigated even if the resident's family do not believe the allegation occurred, ASM #1 stated that with any kind of allegation the facility needs to make sure "There is no fire behind the smoke." On 2/24/21 at 12:48 p.m., ASM #1 was made aware of the above concerns. 2. Review of the clinical record revealed that Resident #1 obtained a head laceration on 2/2/21, 11-7 shift. The following note was documented: "Was notified by CNA (Certified Nursing Assistant) about resident laying in bed with laceration to the forehead, it was also noted that Foley (catheter) was pulled out of patient and	F 609		

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F 609	Continued From page 9	F 609		

laying on the floor. Resident could not verbalize what happened and how injury occur. Upon a full head to toe assessment, resident had 3.0 x 0.5 laceration on the upper left side of eyebrow. No other visible injuries present at this time. Laceration was cleaned with Darkins (sic) and sterile strips applied. 18 Fr (French) Foley was reinserted and hematuria observe. primary care provider (Name) and family (Name of Son, Next of Kin) made aware about incident. Risk management completed, post assessment completed, and incident report completed. Neuro checks initiated and residents vital signs are within normal limits. Resident care plan has been updated and patient is on continues rounding. Resident does not show any signs or pain or discomfort at this time. Bed in lowest position and call bell within reach. will (sic) continue to monitor resident."

Review of Resident #1's clinical record revealed that neurochecks were initiated at 5:45 a.m. and conducted until 8:30 a.m., when medical transport arrived to take Resident #1 to her urology appointment. Resident #1's neurochecks were within normal limits.

The next note by the ADON (Assistant Director of Nursing) documented the following: "When headed to morning meeting, got on elevator with pt (patient) lying on stretcher accompanied by 2 medical transporters. Pt was noted to have an egg-sized hematoma to left side of forehead, slightly discolored blue/purple hues around edges, small laceration noted in middle of hematoma about 3 cm (centimeters) long with 1 steri-strip in middle, small amt of dried blood noted to laceration. When commented about hematoma, "oooh, you did get a nice bump on

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F 609	Continued From page 10	F 609		

you head didn't you?" pt reached up and touched the hematoma, attempted to stop pt from touching hematoma and laceration, explained to pt, to best of my ability, not to touch area. Pt smiled and nodded in understanding."

Review of Resident's #1's Urology appointment summary dated 2/2/21 documented in part, the following: "...presents in office today with head wound due to fall at rehab center, Wound is bleeding and has one butterfly closure. Pt (patient) denies head pain."

Review of Emergency room notes dated 2/2/21 documented in part, the following: "75 yo (year old) female with history of...vascular dementia, presents for evaluation after fall this morning. Foley catheter became dislodged during fall, though pt was taken to Urology clinic...Pt noted to be at baseline mental status. Laceration noted to left forehead. On exam. pt awake and alert...Laceration noted to left forehead without active bleeding...Laceration repair...provided wound care instructions and return timeframe for suture removal."

Review of a witness statement from CNA #1, the CNA present on 2/2/21; documented in part, the following: "I saw her first a little before midnight...she was fine...I saw her again at about 2:15 a.m...she was clean and dry...I looked in room at 3:45 a.m....she was still fine. I came in the room at about 5:30 AM doing my second rounds, her night shift and brief were on the floor in between the two beds...I grabbed clean sheets and a clean gown. I came back in an cleaned her bottom and back side and put clean gown and brief on her right side...I saw the Foley was out on the floor. I didn't want to leave her half nude so I

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F 609	Continued From page 11 went around to put the other side of the gown on. When I turned her I saw the cut on her forehead. I fastened her brief, put her gown on the left arm and went directly to notify the nurse...Nurse gathered supplies for Foley catheter. He informed me that once he was ready, we both went into room together and stayed in the room together while catheter was inserted..." On 2/23/21 at 9:49 a.m., an interview was conducted with RN (Registered Nurse) #1, the nurse who was on duty when Resident #1 obtained the laceration on 2/2/21. When asked how he determined that Resident #1 had a fall on 2/2/21 if she was found lying in her bed and required extensive assistance from one to staff with bed mobility and transfers, RN #1 stated that when the CNA told him that Resident #1 had a laceration to her head and had pulled her Foley out; he went into the room right away and saw the Foley on the ground with the bulb still inflated. RN #1 stated that he assumed by looking at the surroundings that the resident must have fallen out of bed and got herself back into bed. RN #1 stated that the resident had a previous history of falls and that her bed was in a low position when he saw her last. RN #1 stated that he asked the staff if the resident was capable of pulling herself back into bed, and he was told by her assigned nursing aide on duty that she was sometimes able to pull herself up using grab bars. RN #1 stated that he treated this situation as if she had a fall. When asked if he had asked the resident what had happened, RN #1 stated that she didn't speak English and that it seemed like she was trying to tell him something but that he could not understand her. When asked RN #1 if he called her family to see if they could translate what had happened, RN #1 stated that he did not. RN #1	F 609		

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	495210	A. BUILDING _____ B. WING _____	C 02/24/2021

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F 609	Continued From page 12	F 609		

stated that he just told the son that she had fallen. RN #1 stated that later that day he notified the ADON and the ADON informed him that he cannot assume residents have fallen if he did not see the fall and if the resident can not tell him what happened. RN #1 stated that he was given a verbal in-service on identifying the incident as an injury of unknown origin. When asked if after he was educated if then treated the incident like an injury of unknown origin and started an investigation, RN #1 stated that he did not. RN #1 could not recall if the ADON had started an investigation.

On 2/24/21 at 10:12 a.m., an interview was conducted with ASM (Administrative Staff Member) #3, the ADON (Assistant Director of Nursing). When asked how it was determined that Resident #1 had a fall on 2/2/21 if she was found lying in her bed and required extensive assistance from one to staff with bed mobility and transfers; ASM #3 stated, "I don't know how that was determined. I told the nurse that you can't document what you didn't see or didn't know." ASM #3 stated that she educated RN #1 on documenting. When asked at that point, when she found out this information from RN #1, if she then treated Resident #1's injury as an "Injury of Unknown Origin," ASM #3 stated that she did not, that she had a lot going on that morning. ASM #3 stated that she was "racing to set up a clinic at 6:30 a.m." When asked if she checked on Resident #1 to see what had happened, ASM #3 stated that she did not.

On 2/24/21 at 10:37 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #1, the CNA who worked on 2/2/21 11-7 shift. When asked what she could recall happened that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 02/24/2021

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F 609	Continued From page 13 night, CNA #1 stated that the last time she rounded on Resident #1 was around 3:45 a.m. CNA #1 stated that the resident was dry at that point and did not need to be changed. CNA #1 stated that at approximately 5:30 a.m., she went to check in on Resident #1 and saw her lying in bed on her left side. CNA #1 stated that she also noticed feces all over the bed, her brief pulled off and thrown on the floor and her Foley and night shirt were also on the floor. CNA #1 stated that there was no blood on the floor. CNA #1 stated that she immediately grabbed new sheets and a brief and began to clean her up and put new clothes on her. CNA #1 stated that when she turned the resident to the right right, she noticed a big laceration to her forehead near her left eye. CNA #1 stated that she immediately got the nurse and the nurse did an assessment and left the room to gather Foley catheter supplies. CNA #1 stated that she was instructed to remain present while the nurse was re-inserting the Foley. When asked if Resident #1 was able to get herself back into bed if she had fallen out of the bed, CNA #1 stated there was a time when Resident #1 was hanging off her bed and she had witnessed the resident using her upper body to get back into the bed. On 2/24/21 at 2:44 p.m., ASM #4, the corporate nurse was asked if a FRI (Facility Reported Incident) was submitted for the laceration of unknown origin. ASM #4 responded via email with the following: "They only submitted the one FRI (regarding the allegation of sexual abuse) since they believed the laceration to be caused by a fall and to be a part of the allegation of sexual abuse." There was no evidence that a follow up FRI was	F 609		

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F 609	Continued From page 14 also submitted to the appropriate state agencies. On 2/24/21 at 12:48 a.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Abuse/Neglect/Misappropriation/Crime" documents in part, the following: " 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury or not later than 24 hours if the events that caused the allegation does not involve abuse and do not result in serious bodily injury. a. Notify the Virginia Department of Health Office of Licensure and Certification by filing the initial report... b. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or others licensed or certified by DHP (Department of Health Professions)...The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI to the Virginia Department of Health Office of Licensure and Certification. within (5) working days of the incident..." On 2/24/21 at 1:05 p.m., ASM #4, the Corporate	F 609		

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F 609	Continued From page 15 Nurse emailed this writer a Plan of Correction Regarding the above issue. The following in part, was documented: "Resident found in bed with a laceration to forehead, Foley Catheter tubing lying on floor. Resident's daughter made staff aware that resident made an allegation of rape on 2/2/21. Daughter made police aware of the allegation before the facility was able to. Police came to the facility on 2/6/21 and requested that the Administrator send results of his investigation to the officer. 1. FRI done regarding allegation of rape on 2/3/21. 2. Review of chart: RN (Registered Nurse) notified NP (nurse practitioner) via PCC (Point Click Care) conversation after initiating treatment and replacing Foley Cath. 3. RN documented inaccurate information (times, late entry, assumptions of fall). 4. Resident admitted with Foley but no orders were entered for the Foley. 5. RN replaced the Foley without and order.... Action: 1. Resident discharged on 2/2/21. 2. Falls which occurred over the past 30 days were reviewed to ensure than an injury of unknown origin was correctly identified...completion date: 2/15/21. 3. Nurses will be educated on: a. Identifying an injury of unknown origin. b. Accurate documentation of incident. c. MD/NP (Medical Doctor) and RP (Responsible Party) notification of injury, replacement of Foley when pulled out. d. Obtaining orders for treatments, Foley replacement...completion date: 2/19/21. Facility staff will be educated on: a. Abuse	F 609		

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F 609	Continued From page 16 b. Injury of unknown origin c. Timely report of abuse....completion date: 2/16/21. 5. Incident notes will be reviewed by a Nurse to monitor accurate identification of an injury, accurate documentation of an incident, timely notification of the MD/NP on a random weekly basis. A random weekly monitor of residents with Foley cath will be completed to ensure that an order is present for the catheter. Further review of the staff education titled, "ID (Identify) Possible Abuse; Reporting" revealed that facility staff including the facility social worker, DON, ADON and the Facility Administrator were educated on 2/16/21 and 2/19/21. No further information was presented prior to exit.	F 609		
	COMPLAINT DEFICIENCY PAST NON COMPLIANCE			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		3/1/21

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F 610	Continued From page 17 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to identify and investigate an injury of unknown origin that occurred on 2/2/21 for one of 5 sampled Residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on 1/12/21 with diagnoses that included but were not limited to unspecified convulsions, vascular dementia without behavioral disturbance, history of TIA (stroke), retention of urine, type two diabetes mellitus, and muscle weakness. Resident #1's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date of 1/18/21. Resident #1 was coded as being severely impaired in cognitive function scoring 06 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #1 was coded as requiring extensive assistance with two staff members with bed mobility, and transfers, and extensive assistance from one staff with dressing, eating, and personal hygiene, and total dependence on one staff member with toileting. Review of the clinical record revealed that	F 610	Past noncompliance: no plan of correction required.	

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F 610	Continued From page 18 Resident #1 obtained a head laceration on 2/2/21, 11-7 shift. The following note was documented: "Was notified by CNA (Certified Nursing Assistant) about resident laying in bed with laceration to the forehead, it was also noted that Foley (catheter) was pulled out of patient and laying on the floor. Resident could not verbalize what happened and how injury occur. Upon a full head to toe assessment, resident had 3.0 x 0.5 laceration on the upper left side of eyebrow. No other visible injuries present at this time. Laceration was cleaned with Darkins (sic) and sterile strips applied. 18 Fr (French) Foley was reinserted and hematuria (blood in urine) observe. primary care provider (Name) and family (Name of Son, Next of Kin) made aware about incident. Risk management completed, post assessment completed, and incident report completed. Neuro checks initiated and residents vital signs are within normal limits. Resident care plan has been updated and patient is on continues rounding. Resident does not show any signs or pain or discomfort at this time. Bed in lowest position and call bell within reach. will (sic) continue to monitor resident." Review of Resident #1's clinical record revealed that neurochecks were initiated at 5:45 a.m. and conducted until 8:30 a.m., when medical transport arrived to take Resident #1 to her Urology appointment. Resident #1's neurochecks were within normal limits. The next note by the ADON (Assistant Director of Nursing) documented the following: "When headed to morning meeting, got on elevator with pt (patient) lying on stretcher accompanied by 2 medical transporters. Pt (Patient) was noted to have an egg-sized hematoma to left side of	F 610		

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F 610	Continued From page 19 forehead, slightly discolored blue/purple hues around edges, small laceration noted in middle of hematoma about 3 cm long with 1 steri-strip in middle, small amt of dried blood noted to laceration. When commented about hematoma, "oooh, you did get a nice bump on you head didn't you?" pt reached up and touched the hematoma, attempted to stop pt from touching hematoma and laceration, explained to pt, to best of my ability, not to touch area. Pt smiled and nodded in understanding." Review of Resident's #1's Urology appointment summary dated 2/2/21 documented in part, the following: "...presents in office today with head wound due to fall at rehab center, Wound is bleeding and has one butterfly closure. Pt (patient) denies head pain." Review of Emergency room notes dated 2/2/21 documented in part, the following: "75 yo (year old) female with history of...vascular dementia, presents for evaluation after fall this morning. Foley catheter became dislodged during fall, though pt was taken to Urology clinic...Pt noted to be at baseline mental status. Laceration noted to left forehead. On exam. pt awake and alert...Laceration noted to left forehead without active bleeding...Laceration repair...provided wound care instructions and return timeframe for suture removal." Review of a witness statement from CNA #1, the CNA present on 2/2/21; documented in part, the following: "I saw her first a little before midnight...she was fine...I saw her again at about 2:15 a.m...she was clean and dry...I looked in room at 3:45 a.m....she was still fine. I came in the room at about 5:30 AM doing my second	F 610		

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F 610	Continued From page 20 rounds, her night shift and brief were on the floor in between the two beds...I grabbed clean sheets and a clean gown. I came back in an cleaned her bottom and back side and put clean gown and brief on her right side...I saw the Foley was out on the floor. I didn't want to leave her half nude so I went around to put the other side of the gown on. When I turned her I saw the cut on her forehead. I fastened her brief, put her gown on the left arm and went directly to notify the nurse...Nurse gathered supplies for Foley catheter. He informed me that once he was ready, we both went into room together and stayed in the room together while catheter was inserted..." On 2/23/21 at 9:49 a.m., an interview was conducted with RN (Registered Nurse) #1, the nurse who was on duty when Resident #1 obtained the laceration on 2/2/21. When asked how he determined that Resident #1 had a fall on 2/2/21 if she was found lying in her bed and required extensive assistance from one to staff with bed mobility and transfers, RN #1 stated that when the CNA told him that Resident #1 had a laceration to her head and had pulled her Foley out; he went into the room right away and saw the Foley on the ground with the bulb still inflated. RN #1 stated that he assumed by looking at the surroundings that the resident must have fallen out of bed and got herself back into bed. RN #1 stated that the resident had a previous history of falls and that her bed was in a low position when he saw her last. RN #1 stated that he asked the staff if the resident was capable of pulling herself back into bed, and he was told by her assigned nursing aide on duty that she was sometimes able to pull herself up using grab bars. RN #1 stated that he treated this situation as if she had a fall. When asked if he had asked the resident	F 610		

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F 610	Continued From page 21 what had happened, RN #1 stated that she didn't speak English and that it seemed like she was trying to tell him something but that he could not understand her. When asked RN #1 if he called her family to see if they could translate what had happened, RN #1 stated that he did not. RN #1 stated that he just told the son that she had fallen. RN #1 stated that later that day he notified the ADON and the ADON informed him that he cannot assume residents have fallen if he did not see the fall and if the resident can not tell him what happened. RN #1 stated that he was given a verbal in-service on identifying the incident as an injury of unknown origin. When asked if after he was educated if then treated the incident like an injury of unknown origin and started an investigation, RN #1 stated that he did not. RN #1 could not recall if the ADON had started an investigation. On 2/24/21 at 10:12 a.m., an interview was conducted with ASM (Administrative Staff Member) #3, the ADON (Assistant Director of Nursing). When asked how it was determined that Resident #1 had a fall on 2/2/21 if she was found lying in her bed and required extensive assistance from one to staff with bed mobility and transfers; ASM #3 stated, "I don't know how that was determined. I told the nurse that you can't document what you didn't see or didn't know." ASM #3 stated that she educated RN #1 on documenting. When asked at that point, when she found out this information from RN #1, if she then treated Resident #1's injury as an "Injury of Unknown Origin," ASM #3 stated that she did not, that she had a lot going on that morning. ASM #3 stated that she was "racing to set up a clinic at 6:30 a.m." When asked if she checked on Resident #1 to see what had happened, ASM #3	F 610		

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F 610	Continued From page 22 stated that she did not. When asked how staff communicated with Resident #1, ASM #3 stated that the Director of Rehab could speak Spanish and would come in to see the resident every day. When asked if the Director of Rehab worked 11-7 shift, ASM #3 stated that she did not. When asked if anyone alerted the Director of Rehab to come talk to Resident #1 later in the morning prior to Resident #1's urology appointment, ASM #3 stated that she didn't think so. ASM #3 stated that she would have expected RN #1 to call the family to translate what the resident was trying to convey to the nurse. On 2/24/21 at 10:37 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #1, the CNA who worked on 2/2/21 11-7 shift. When asked what she could recall happened that night, CNA #1 stated that the last time she rounded on Resident #1 was around 3:45 a.m. CNA #1 stated that the resident was dry at that point and did not need to be changed. CNA #1 stated that at approximately 5:30 a.m., she went to check in on Resident #1 and saw her lying in bed on her left side. CNA #1 stated that she also noticed feces all over the bed, her brief pulled off and thrown on the floor and her Foley and night shirt were also on the floor. CNA #1 stated that there was no blood on the floor. CNA #1 stated that she immediately grabbed new sheets and a brief and began to clean her up and put new clothes on her. CNA #1 stated that when she turned the resident to the right right, she noticed a big laceration to her forehead near her left eye. CNA #1 stated that she immediately got the nurse and the nurse did an assessment and left the room to gather Foley catheter supplies. CNA #1 stated that she was instructed to remain present while the nurse was re-inserting the Foley. When	F 610		

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F 610	Continued From page 23 asked if Resident #1 was able to get herself back into bed if she had fallen out of the bed, CNA #1 stated there was a time when Resident #1 was hanging off her bed and she had witnessed the resident using her upper body to get back into the bed. On 2/24/21 at 12:48 a.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. On 2/24/21 at 1:05 p.m., ASM #4, the Corporate Nurse emailed this writer a Plan of Correction Regarding the above issue. The following in part, was documented: "Resident found in bed with a laceration to forehead, Foley Catheter tubing lying on floor. Resident's daughter made staff aware that resident made an allegation of rape on 2/2/21. Daughter made police aware of the allegation before the facility was able to. Police came to the facility on 2/6/21 and requested that the Administrator send results of his investigation to the officer. 1. FRI done regarding allegation of rape on 2/3/21. 2. Review of chart: RN (Registered Nurse) notified NP (nurse practitioner) via PCC (Point Click Care) conversation after initiating treatment and replacing Foley Cath. 3. RN documented inaccurate information (times, late entry, assumptions of fall). 4. Resident admitted with Foley but no orders were entered for the Foley. 5. RN replaced the Foley without and order.... Action: 1. Resident discharged on 2/2/21. 2. Falls which occurred over the past 30 days	F 610		

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F 610	Continued From page 24 were reviewed to ensure than an injury of unknown origin was correctly identified...completion date: 2/15/21. 3. Nurses will be educated on: a. Identifying an injury of unknown origin. b. Accurate documentation of incident. c. MD/NP (Medical Doctor) and RP (Responsible Party) notification of injury, replacement of Foley when pulled out. d. Obtaining orders for treatments, Foley replacement...completion date: 2/19/21. Facility staff will be educated on: a. Abuse b. Injury of unknown origin c. Timely report of abuse....completion date: 2/16/21. 5. Incident notes will be reviewed by a Nurse to monitor accurate identification of an injury, accurate documentation of an incident, timely notification of the MD/NP on a random weekly basis. A random weekly monitor of residents with Foley cath will be completed to ensure that an order is present for the catheter. Further review of the staff education titled, "ID (Identify) Possible Abuse; Reporting" revealed that facility staff including the facility social worker, DON, ADON and the Facility Administrator were educated on 2/16/21 and 2/19/21. No further information was presented prior to exit. COMPLAINT DEFICIENCY PAST NON COMPLIANCE	F 610		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		3/1/21

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	495210	A. BUILDING _____ B. WING _____	C 02/24/2021

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F 690	Continued From page 25 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record it was determined that	F 690	Past noncompliance: no plan of correction required.	

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F 690	Continued From page 26 facility staff failed to obtain an order for the use of a Foley catheter for one of five sampled residents; Resident #5. The findings included: Resident #1 was admitted to the facility on 1/12/21 with diagnoses that included but were not limited to unspecified convulsions, vascular dementia without behavioral disturbance, history of TIA (stroke), retention of urine, type two diabetes mellitus, and muscle weakness. Resident #1's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date of 1/18/21. Resident #1 was coded as being severely impaired in cognitive function scoring 06 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #1 was coded as requiring extensive assistance with two staff members with bed mobility, and transfers, and extensive assistance from one staff with dressing, eating, and personal hygiene, and total dependence on one staff member with toileting. Resident #1 was coded in Section H (Bowel and Bladder) as having a urinary catheter. Review of Resident #1's clinical record revealed that she was admitted to the facility with a Foley catheter in place. The first documented note regarding her Foley was on 1/13/21 by the physician. The following in part, was documented: "...She had acute urinary retention. She required a Foley catheter. She failed a voiding trial and remains with a Foley catheter." Further review of Resident #1's clinical record revealed no orders for the use of a Foley Catheter.	F 690		

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F 690	Continued From page 27 Review of Resident #1's hospital discharge instructions dated 1/12/21 failed to evidence orders for the Foley Catheter. Resident #1's care plan dated 1/12/21 failed to evidence any care instructions for the use of her Foley catheter. Review of the clinical record revealed that Resident #1 pulled out her Foley catheter on 2/2/21 on 11-7 shift. The following note was documented: "Was notified by CNA (Certified Nursing Assistant) about resident laying in bed with laceration to the forehead, it was also noted that Foley was pulled out of patient and laying on the floor. Resident could not verbalize what happened and how injury occur...18 Fr (French) Foley was reinserted and hematuria (blood in urine) observe. primary care provider (Name) and family (Name of Son, Next of Kin) made aware about incident." There was no evidence of a physician order to re-insert Resident #1's Foley catheter. On 2/23/21 at 9:49 a.m., an interview was conducted with RN (Registered Nurse) #1, the nurse who was on duty when Resident #1's Foley was observed on the floor. When asked what had occurred after he saw Resident #1's Foley pulled out, RN #1 stated that he grabbed Foley supplies and because the resident previously had a 18 FR Foley in place, he re-inserted an 18 Fr Foley with the nursing aide present. When asked if Resident #1 had an order for an 18 FR Foley catheter, RN #1 stated that he was not sure, that he didn't even check for an order at that time. When asked who was responsible for ensuring orders are in place	F 690		

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F 690	Continued From page 28 at the time of an admission for the use of a Foley catheter, RN #1 stated that the nurse doing the admission nurse would be responsible. When asked of he knew if Resident #1 had orders in place for the use of her Foley, RN #1 stated, "No. I don't." When asked what catheter orders would specify, RN #1 stated that catheter orders included directions of how often to change the Foley, Foley care every shift, and an order for the use of the Foley including size and diagnosis. When asked why Resident #1 had a Foley in place, RN #1 stated that Resident #1 had urinary retention. On 2/24/21 at 10:12 a.m., an interview was conducted with ASM (Administrative Staff Member) #3, the ADON (Assistant Director of Nursing). When asked if orders were required for the use of a Foley Catheter, ASM #3 stated, "Yes, we have to have orders." ASM #3 stated that orders usually specified the size and diagnosis for the use of the Foley as well as orders specifying when to change the Foley. ASM #3 stated that the facility usually changed the Foley every 30 days from the day it was inserted. When asked why Resident #1 had a Foley, ASM #3 stated that she had urinary retention with previous failed voiding trials in the hospital. When asked if Resident #1 had an order for the use of the Foley, ASM #3 stated that she did not know. ASM #3 stated that she would have expected the nurse doing Resident #1's admission to put Foley orders in place, or clarify if directions were not on the hospital discharge paperwork. On 2/24/21 at 12:48 a.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 690		

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F 690	Continued From page 29 On 2/24/21 at 12:51 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 confirmed that Resident #1 did not have orders for the use of her Foley Catheter. Facility policy titled, "Urinary/Catheter Care," documented in part, the following: "Licensed nurses may perform indwelling, in an out urinary catheterization, removal of urinary catheters and application of External Catheters with physician's orders..." On 2/24/21 at 1:05 p.m., ASM #4, the Corporate Nurse emailed this writer a Plan of Correction Regarding the above issue. The following in part, was documented: "Resident found in bed with a laceration to forehead, Foley Catheter tubing lying on floor. Resident's daughter made staff aware that resident made an allegation of rape on 2/2/21. Daughter made police aware of the allegation before the facility was able to. Police came to the facility on 2/6/21 and requested that the Administrator send results of his investigation to the officer. 1. FRI done regarding allegation of rape on 2/3/21. 2. Review of chart: RN (Registered Nurse) notified NP (nurse practitioner) via PCC (Point Click Care) conversation after initiating treatment and replacing Foley Cath. 3. RN documented inaccurate information (times, late entry, assumptions of fall). 4. Resident admitted with Foley but no orders were entered for the Foley. 5. RN replaced the Foley without and order.... Action: 1. Resident discharged on 2/2/21.	F 690		

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F 690	Continued From page 30 2. Falls which occurred over the past 30 days were reviewed to ensure than an injury of unknown origin was correctly identified...completion date: 2/15/21. 3. Nurses will be educated on: a. Identifying an injury of unknown origin. b. Accurate documentation of incident. c. MD/NP (Medical Doctor) and RP (Responsible Party) notification of injury, replacement of Foley when pulled out. d. Obtaining orders for treatments, Foley replacement...completion date: 2/19/21. Facility staff will be educated on: a. Abuse b. Injury of unknown origin c. Timely report of abuse....completion date: 2/16/21. 5. Incident notes will be reviewed by a Nurse to monitor accurate identification of an injury, accurate documentation of an incident, timely notification of the MD/NP on a random weekly basis. A random weekly monitor of residents with Foley cath will be completed to ensure that an order is present for the catheter. Further review of the staff education revealed that nursing staff were educated on the replacement of a Foley catheter with a physician's order on 2/19/21. No further information was presented prior to exit. COMPLAINT DEFICIENCY PAST NON COMPLIANCE	F 690		