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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 6/14/2021 through 6/15/2021. Four complaints (VA00048353, VA00048990, VA00050247, VA00052166) were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 176 bed facility was 110 at the time of the survey. The survey sample consisted of eight current Resident reviews, (Residents # 1, #3, #5, #6, #7, #8, #9 and #10) and two closed record reviews, (Residents # 2 and #4).	F 000	This Plan of Correction is submitted in accordance with established State and Federal laws. Submission of this Plan of Correction is not an admission of a deficiency existing or that a deficiency was cited correctly, it constitutes written allegation of compliance for deficiencies cited.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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 interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to provide supervision, assistive devices, and environment free of hazards to prevent injury for two of ten residents in the survey sample, (Resident #1 and Resident #7). 1. The facility staff failed to ensure Resident #1,	F 689	1. Corrective action for the alleged deficient practice in regards to Resident #1 and #7 has been accomplished as follows. Resident #1 had his WanderGuard replaced and is now being checked per MD/NP orders. Staff is providing supervision on and off the unit so as to keep him safe and free from injury. Resident #7 had the fall mat put into place beside the bed as stated in the care plan and it is being monitored by staff for proper placement so as to provide the resident with a safe environment. Staff was educated at the time of the incident regarding the proper way to check the Wander Guards to ensure they are functioning appropriately and on following MD/NP orders for ongoing checks for placement and function.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ramona J. Rmastaff — TITLE: Administrator — (X6) DATE: 7/1/2021

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 689	Continued From page 1 with diagnoses including dementia and a stroke, who was mobile in a wheelchair, with wandering behaviors and a wander guard in place, and coded as severely impaired for cognition, was not able to exit the facility unsupervised through the front doors. On 6/5/2, at approximately 5:00 p.m., Resident #1 wandered off the unit where he resided, exited the facility in his wheelchair through the front doors onto the porch unsupervised, turned his wheelchair over, and fell down three steps, sustaining injuries including, a hematoma to his head and a fractured clavicle, resulting in harm. Staff interviews revealed the front door wander guard alarm never sounded. 2. The facility staff failed to implement Resident #7's fall mat on 6/14/21 and 6/15/21, per the comprehensive plan of care. The findings include: 1. Resident #1 was admitted to the facility on 5/10/2014 with a readmission on 8/23/2020 with diagnoses that included but were not limited to: stroke (1), hemiplegia (paralysis affecting only one side of the body) (2), history of falls, atrial fibrillation (3), dementia and fracture left clavicle (collar bone). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/12/2021, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for moving in the bed, transfers, locomotion on the unit, dressing, toileting,	F 689	2. Current facility residents deemed to require a WanderGuard or in need of a fall mat have the potential to be affected by the alleged deficient practice. A 100% audit of residents with a WanderGuard or a fall mat will be completed to asssure there is adequate supervision of these residents by staff so as to prevent accidents and provide a safe environment. 3. Measures put into place to assure alleged deficient practice does not recur include: Facility Nursing staff will be provided with education regarding the checking of placement and function of WanderGuards in use for resident safety per MD/NP order and the implementation of fall mats care planned for resident safety. QA nurse/designee will complete a 100% audit of MAR and TAR of residents ordered WanderGuard for placement and function and 100% of residents care planned for fall mats weekly x 3 months. Any identified concerns will be brought to the attention of the DON/designee so that reeducation can occur as needed. The Central Supply employee/designee will do an observational audit for 100% of residents wearing WanderGuards for placement, function, and expiration date and of residents with fall mat placement weekly x 3 months as a second check to assure compliance. Any identified concerns will be reported to the DON/designee so that corrective action can be accomplished. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the weekly Risk Management Meeting x 3 months. Any ongoing issues will be reported to the Quality Assurance committee quarterly for a minimum of six months. They will evaluate the effectiveness of the plan and the plan will be adjusted as the committee may recommend, based on any outcomes/trends identified. 5. Completion Date: July 5, 2021	

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personal hygiene and bathing. Resident #1 was coded as requiring supervision after set up assistance was provided for eating. In Section E - Behaviors, the resident was not coded as having wandering behavior during the lookback period.

The Facility Reported Incident (FRI) dated 6/8/2021 documented in part, "Incident Date: June 5, 2021. Injuries: (an X was documented beside) Yes ... If yes, describe: un-displaced fracture of distal left clavicle acute. Describe incident including location and action taken: Resident observed out front of the facility at the bottom of the set of 3 stairs with wheelchair resting on his left side at the bottom of the stairs. The RN (registered nurse) supervisor immediately assessed resident for injury. Resident noted with abrasions to his left shoulder, elbow, and left knee. First aid rendered by RN. No changes noted in resident's cognitive status, resident did complain of discomfort in left elbow. Resident assessed with ROM (range of motion) within residents normal limits, no changed to ROM noted. Neuro (neurological) checks within normal limits. Assisted back into wheelchair and into facility. Resident had frequently in past sat on the front porch to visit with his family and when asked if that was what he was attempting to do resident stated 'yes.' The Nurse Practitioner on call made aware of the fall, abrasions and small closed hematoma to top of head, as well as resident on anticoagulant twice daily. No new orders obtained at time of fall. Residents' POA (power of attorney) also made aware of the fall. Neuro [neurological] checks completed throughout the evening per protocol and were within normal limits. Resident denied complaints of pain or discomfort. On June 6, 2021, the Director of Nursing notified of the fall. Director of

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Nursing contacted Nurse Practitioner and discussed and decisions made, and order given to send resident to emergency room, via 911 for evaluation. Director of Nursing called ER (emergency room) to check status of resident and was informed that the resident had gotten a CT (computerized tomography) of the head and some lab (laboratory) work and all were negative. Director informed that resident would be returning to facility. Resident returned to the facility and placed on Wing (number) per protocol. On June 7, 2021, Resident complained of left shoulder pain with care. Nurse Practitioner notified and ordered an X-ray of the left shoulder. Results received at the facility at approximately 9:30 p.m., Nurse Practitioner and Director of Nursing notified of X-ray results showing un-displaced fracture of the distal left clavicle. Resident again sent to ER via 911 for evaluation and returned to the facility with sling on left arm. Resident seen by Nurse Practitioner on June 8, 2021 and had complaints of pain in left shoulder. New order received for pain medication. POA aware of all of the above findings. Resident Care Plan to be reviewed and revised. Upon further investigation (Resident #1) is a 83 year old male with a history of CVA (stroke), right sided non dominant hemiplegia, history of falls, osteoporosis, dementia without behavioral disturbances and major depressive disorder. As noted above, resident was observed out front of the facility at the bottom of a set of 3 stairs resting on his left side. The RN supervisor assessed Resident and first aid was rendered. Resident denied complaint of pain or discomfort at the time, no guarding of body part, nor signs of nonverbal pain such as grimacing or wincing. He was noted to have abrasions to his left shoulder, elbow and knee. There was no noted deformity or edema to any body part. Resident was

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assisted into his wheelchair and taken back to his room. NP (nurse practitioner) was notified and order was received to send resident to ED (emergency department) for further evaluation. All testing was negative and resident was sent back to the facility. On 6/7/21 resident began to complaint of left arm and shoulder pain. The NP ordered an x-ray of the area results showed a non-displaced distal left clavicle fracture. The resident was again sent to the ER for further evaluation and returned to the facility with an order for an arm sling to be worn for resident comfort. Resident had a history of sitting in the lobby daily and would go out on the front porch to wait for his son to visit. Resident acknowledge (sic) he was trying to do that but appears he got to (sic) close to the edge and the wheel of the wheelchair slipped off the edge of the stair. The resident was wearing a wander guard to remind resident to ask for assistance to go outside but he was able to go out on his own. As the incident was unwitnessed, it is unclear if the wander guard stopped functioning or if someone had exited the building and he followed them outside. The wander guard was being checked each shift. Nursing staff had been educated to assist resident to high visibility area when out of bed in his wheelchair. Wander guard is on resident and is functioning."

The incident report dated 6/5/2021 at 17:04 (5:04 p.m.) documented in part, "Incident Location: outside. Nursing Description: CNA informed this nurse that resident had fallen outside. This nurse observed resident lying on left side, wheelchair next to resident. Immediate Action Taken: Assessment reformed by this nurse. VSS. Resident alert, oriented to baseline. Verbal responses limited, 'yes/no.' C/o (complained of)

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pain to left elbow. PERRLA [pupil, equal, round, reactive to light and accommodation]. No jugular vein distention observed. Pulses palpable, even. No edema observed. Respirations even, non-labored on RA (room air). No cough or SOB (shortness of breath) observed. Abdomen soft non-tender. Right extremities moved at baseline, left side flaccid. Skin warm, dry. Abrasion to left scalp/left elbow observed. Supervising RN, NP and family notified. No additional orders received. First aid to wounds performed by RN. Neurological checks initiated. Assessment negative. Resident assisted back to wheelchair by staff. Mental Status: Checked were Oriented to Place and Oriented to Person ...Predisposing Physiological Factors: Other was checked. Other info (information) wanderguard (sic) in place LLE [left lower extremity]. Predisposing Situation Factors: a check mark was next to Active Exit Seeker and Wanderer. Witnesses: No witnesses found."

The nurse's note dated 6/5/2021 at 6:45 p.m. documented, "CNA (certified nursing assistant) notified this nurse that resident had fallen outside. The nurse observed resident lying on left side, wheelchair. Assessment performed by this nurse. VSS (vital signs stable). Resident alert, oriented to baseline. Verbal responses limited to 'yes/no' C/o (complained of) pain to left elbow. PERRLA (pupils equal, round, reactive to Light, Accommodation). No jugular vein distention observed. Pulses palpable, even. No edema observed. Respirations even, non-labored on RA (room air). No cough or SOB (shortness of breath) observed. Abdomen soft non-tender. Right extremities moved at baseline, left side flaccid. Skin warm, dry. Abrasion to left scalp/left elbow observed. Supervising RN, NP and family

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notified. No additional orders received. First aid to wounds performed by RN. Neurological checks initiated. Assessment negative. Resident assisted back to wheelchair by staff."

The nurse's note dated 6/6/2021 at 2:16 p.m. documented, "Note text: 0930 (9:30 a.m.) resident was sent to hospital d/t (due to) s/p (status post) fall on 6/5/21 for checkup from fall ---supervisor (name of supervisor) informed son (name of son) of transfer."

The nurse's note dated 6/6/2021 at 4:55 p.m. documented, "Late Entry: Resident return from hospital with no new orders. Tetanus vaccine administer and updated in immunization record. All lab work was WNL (within normal limits) and CT negative."

The nurse practitioner note dated 6/7/2021 at 10:35 a.m. documented in part, "Reason for visit - pt (patient) went out front door this weekend and ended up at bottom of steps in w/c (wheelchair). NP [nurse practitioner] on call notified and felt he was stable as long as neuro checks were obtained and stable. I received phone call letting myself know of the incident and decided to send to (initials of hospital) for evaluation since he currently on blood thinners to ensure he is stable to be in facility over weekend. He returned and CT [computed tomography] scan negative, VS (vital signs) stable and in chart...Assessment/Plan: fall down steps - sent to (initials of hospital) - CT was negative, he has superficial abrasion left elbow and left knee. New wander guard intact to ankle."

The nurses' note dated 6/7/2021 at 9:41 p.m. documented, "Resident complaining of left

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shoulder pain and NP ordered x-ray from post fall day before. X-ray positive for left clavicle fx (fracture) and NP ordered to be sent back to ER, son (name of son) was called about updates and aware."

The nurse's note dated 6/8/2021 at 1:35 a.m. documented in part "Resident returned from (initials of hospital) ED at this hour with 'closed nondisplaced fracture of acromial end of left clavicle.' Pt in sling to L (left) arm. Awake and alert. C/O of pain with transfer and turning but settles immediately after...Has order to follow up with (name of orthopedist) in one week."

The physician order dated 6/11/2020 documented, "Apixaban Tablet (used help prevent strokes or blood clots in people who have atrial fibrillation) (4) 5 mg (milligram), give 1 tablet by mouth every 12 hours related to atrial fibrillation.

The physician order dated 8/23/2020 documented, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk."

Review of the TAR (treatment administration record) for May 2021 documented in part, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk." All boxes for all shifts were documented as having been checked.

The TAR for June 2021 documented in part, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk." All but two night shift boxes were documented from 6/1/2021 thru 6/13/2021.

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The Radiology Report dated, 6/7/2021 documented in part, "Findings: There is an undisplaced fracture of the distal clavicle acute. There may be a possible undisplaced fracture 3-4 cm (centimeters) proximal to the acute fracture at the distal left clavicle."

The comprehensive care plan dated 8/24/2018 and revised on 6/5/2021 documented in part, "Focus: On one occasion, resident wandered to the front door of the facility." Another entry dated 6-5-21, documented, "Resident wandered to the front door of the facility and went out the front door." The "Interventions/Tasks" dated 8/24/2018, documented, "Wander Alert is in place for resident's safety LLE [left lower extremity]. Monitor location of resident and redirect as needed. Document wandering behavior and attempted diversional interventions in progress note. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers:" This was left blank. The care plan, dated 6/8/2021, also documented in part, "Focus: The resident had an actual fall 6/5/21 with injury." The "Interventions/Tasks" documented, "Assist resident to high visibility area when in wheelchair. Continue interventions on the at-risk plan."

Resident #1 was observed on 6/14/2021 at 11:32 a.m. sitting in his wheelchair in the day room. He was seated at a table with a sling on his left arm and splints applied to his right arm.

On 6/14/2021 at 1:49 p.m., an interview was conducted with LPN (licensed practical nurse) #2, a nurse on the unit where Resident #1 resided. When asked if they had any residents that wandered, LPN #2 stated that they had one

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recently (Resident #1). LPN #2 stated, the resident [Resident #1] was used to sitting outside out front. When asked how the resident gets out front, LPN #2 stated he self-propels in his wheelchair. LPN #2 further stated that he had a wander guard on his left lower extremity. When asked who monitors the wander guards, LPN #2 stated that the 11:00 p.m. to 7:00 a.m. shift nurse makes sure they are functioning. LPN #2 stated she checks for placement only, she didn't check for functioning. When asked how Resident #1 got through the front door, LPN #2 stated, "The wander guard should have gone off." When asked where the functioning checks are documented, LPN #2 stated in the TAR. At this time LPN #2 got up and redirected Resident #1 from self-propelling down the hallway. When asked how Resident #1 got out with a wander guard in place, LPN #2 stated she was not here when it happened.

On 6/14/2021 at 2:01 p.m. observation of the front entrance revealed two steps to get from the sidewalk to the first landing. Then a landing that is 62 inches deep and 101 - 103 inches wide between the two sets of iron railings. From this landing were three more steps to another landing and then the entrance into to the facility. Observation revealed a person can exit out of the building but cannot enter the building without being let in by a staff member due to the COVID [coronavirus] restrictions in place and screening of anyone that comes in the building.

On 6/14/2021 at 2:19 p.m., an interview was conducted with OSM (other staff member) # 2, the maintenance director, When asked how often the wander guards are checked for function, OSM #2 stated he does not check for that. When

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asked how often the doors are checked to ensure the wander guard system is working, OSM #2 stated he checks the doors, front door and Wing 3 door, twice a day, Monday through Friday. When asked if there had been any problems lately with the system, OSM #2 stated there had not been any concerns on his part. OSM #2 provided the documentation of his checking the wander guard system twice a day Monday through Friday. Review of the documentation provided revealed OSM #2 completed audits Monday through Friday twice a day as stated. No issues were documented. OSM #2 stated that when a resident with a wander guard gets close to the door, it should go off. It [the wander guard system] goes off within five or less feet from the door. At this time OSM #2 was observed testing the front door wander guard system and a loud alarm sounded evidencing the system was functioning. Further observation revealed a staff member coming out of an office down the hall in response to the alarm to see what was going on.

On 6/14/2021 at 2:55 p.m., an interview was conducted with RN (registered nurse) #1, who was assigned to Resident #1 on 6/5/2021. When asked to describe what happened on 6/5/2021, RN #1 stated, "She was not there when it happened. She was outside on the back patio with the residents that smoke. I saw three nurses and two aides were outside out the front door. I didn't realize it was (Resident #1)". RN #1 stated, "(Resident #1) had sneaked off the unit and the two aides were busy attending to other resident's needs. (LPN #4) was doing her medications. One of the aides asked where (Resident #1) was, and they searched his room, halls and then started looking off the unit for him". When asked if the alarm for the wander guard went off, RN #1

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stated she "didn't hear it." RN #1 stated, "They brought him [Resident #1] back to his room. We assessed him, did neurological assessment, and pain assessment. I spoke with the nursing supervisor (RN #2)." When asked if she checked the wander guard, RN #1 stated no one checked it at that time. RN #1 stated, "She looked at the wander guard and it was expired." When asked the date of the wander guard, RN #1 stated, "It said, 06/01/2021." RN #1 stated she figured it needed to be replaced. When asked if she replaced it, RN #1 stated, she did not, it had to be replaced on Monday and she had to request it. She stated she gave her report to the oncoming shift to let everyone know about it. When asked how staff check the placement and function of the wander guard, RN #1 stated she had not been taught to check the functioning of it, she knew how to check where it was but she had never been taught where to get the box to check it [to see if the wander guard was functioning]. When asked about the location of the box (the box is a silver grey box approximately 4 ½ inches in length, approximately 3 inches in width and approximately 1 ½ to 2 inches in depth), RN #1 stated it was now in the treatment cart. When asked if she had access to a new wander guard on the weekends, RN #1 stated the nurses told me it would be replaced on Monday. RN #1 stated that when the resident returned from the hospital, 6/6/2021, she was shown how the box works and the new one [wander guard] that had been placed on his [Resident #1's] leg. Resident #1's TAR for June was reviewed with RN #1. She verified her initials. RN #1 was asked how she could sign off checking the function of the wander guard if she didn't check it. RN #1 stated, "A nurse told her that as long as she saw it on him [Resident #1], she could sign it off." Resident #1's

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TAR documented RN #1 had signed off as completing "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk", on 6/1/2021, 6/3/2021, and 6/5/2021.

An interview was conducted with LPN #3 on 6/14/2021 at 3:51 p.m., regarding the process followed for an order to check for placement and functioning of a wander guard every shift. LPN #3 stated, "The machine is in the treatment room. You take the box and scan it over the top of the wander guard and it flashes green it's functioning." When asked if both placement and functioning of a wander guard is checked if the order by the physician includes both, LPN #3 stated, yes. LPN #3 stated, "She usually keeps a close eye on Resident #1 as he will take off when no one is looking." LPN #3 stated, "Before COVID, he [Resident #1] would sit in the lobby. He wouldn't go outside, just sat there." LPN #3 stated she was not on duty when Resident #1 fell. When asked if staff should sign off something, they didn't do, LPN #3 stated, no, you should only sign off something that you did.

On 6/14/2021 at 4:11 p.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA assigned to Resident #1's unit on 6/5/2021. CNA #1 was asked to explain what happened with Resident #1 on 6/5/2021. CNA #1 stated there were two aides assigned to the unit that evening. She and the other aide were doing their rounds. At that time the resident [Resident #1] was sitting in the living room/day room. CNA #1 stated then I saw him [Resident #1] in the middle of the hallway at the nurse's station. CNA #1 stated she came out of a resident's room and didn't see him [Resident #1]. CNA #1 stated she

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called (CNA #2) and we went looking for him, in his room, down the halls, and then in the lobby. CNA #1 stated, "We [CNA #2 and I] then saw him [Resident #1] outside down the steps; he had fallen out of his wheelchair and was on his side." When asked if CNAs do any checking of the wander guard systems, CNA #1 stated, no. When asked if she heard the wander guard alarm when Resident #1 went out the facility front door, CNA #1 stated she didn't hear the alarm. When asked if they can hear the alarm on the unit with the doors to the unit closed, CNA #1 stated, "Yes, there is a box on the ceiling of the nurse's station and it's very loud." CNA #1 stated, "If the alarm had gone off we would have been able to get to him." CNA #1 further stated that when they found Resident #1, his wheelchair was practically on top of him.

On 6/14/2021 at 4:15 p.m., an interview was conducted with LPN #4, the other nurse assigned to the wing where Resident #1 resided on 6/5/2021. When asked if she was involved when Resident #1 fell, LPN #4 stated, "She was on the unit as a nurse. His nurse was taking the smokers outside to smoke. The CNAs came and got me stating that the resident [Resident #1] was lying outside on the ground." When asked if she heard the alarm for the wander guard, LPN #4 stated, "She did not hear it, the other aide did not hear it but it [the wander guard] was in place on Resident #1's leg." When asked who checks the functioning of the wander guards, LPN #4 stated she did. LPN #4 stated, "There is a box in the treatment cart. You place it near the wander guard and wait for the light to light up. If it's green it's okay but if it's red, the wander guard needs to be replaced." When asked what happened on that evening when Resident #1 fell, LPN #4

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stated, "She and other nurses and aides, brought him [Resident #1] back and his nurse [RN #1] and the supervisor stated it [Resident #1's wander guard] wasn't working." LPN #4 stated, "When the CNAs came and got me we did an assessment of the resident prior to putting him in the wheelchair."

On 6/14/2021 at 4:19 p.m., an interview was conducted with CNA #2, assigned to the wing where Resident #1 resided on 6/5/2021. CNA #2 stated she did not witness what happened. CNA #2 stated that she and the other aide noted he [Resident #1] was not where he was before we went on our rounds. CNA #2 stated, "We found him outside on the landing with the wheelchair practically on top of him." When asked if she heard the wander guard alarm, CNA #2 stated that they didn't hear it. CNA #2 stated she had brought this up to (RN #2) the supervisor, that they didn't hear the alarm. CNA #2 stated his nurse was out back with the smokers and no one heard the alarm. When asked if it was brought up that the resident's wander guard was expired, CNA #2 stated, "the nurse (LPN #4) told us that the wander guard had expired."

On 6/14/2021 at 4:32 p.m., an interview was conducted with RN #2, the weekend supervisor. When asked to describe what happened to Resident #1 on 6/5/2021, RN #2 stated, "She didn't remember how she was called but she was called up front of the building. (Resident #1) was in his wheelchair at the front entrance. I was told he had gone down the first three steps, he was found on the first landing." When asked how he got into the wheelchair, RN #2 stated, "The nurse (LPN #4) told me she had done an assessment and got him back in his wheelchair." RN #2 stated

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she did her own assessment. She stated the resident is aphasic and she asked if he was hurt and he told her no. RN #2 stated, "The resident had scrapes on his shoulder, elbow and a hematoma forming on his head above his left ear." RN #2 stated she called the NP [nurse practitioner] on call. RN #2 stated she was not comfortable with the decision of the NP to not send him [Resident #1] to the hospital for evaluation. When asked if she heard the wander guard alarm go off, RN #2 stated she did not hear it. When asked if his wander guard was working at the time of the incident, RN #2 stated, "We didn't realize it didn't work." RN #2 stated, "Resident #1 wanders off but we catch him, normally." When asked how the wander guard is checked for placement and functioning, RN #2 stated we use the box to check it. When asked if someone signed it off and didn't check the function, RN #2 stated, "That's not good."

On 6/14/2021 at 5:04 p.m., LPN #3 was observed testing Resident #1's wander guard. Resident #1's wander guard demonstrated a green light that indicated it was functioning.

On 6/14/2021 at 5:19 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked if any staff member is at the reception desk during the weekend, ASM #1 stated, not unless the business office manager is the manager on duty and they will sometimes be at the desk.

On 6/15/2021 at 8:07 a.m., an interview was conducted with LPN #5, a nurse on Wing 3. When asked how she checks a wander guard for placement and functioning, LPN #5 stated the machine is in the medication cart. LPN #5 stated,

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"She also has to check the expiration date [on the wander guard], as it won't function if it's expired." When asked where the nursing staff document that they have checked the placement and function of the wander guard, LPN #5 stated it is documented on the TAR.

On 6/15/2021 at 8:23 a.m., an interview was conducted with OSM #1, the supply staff member regarding the wander guards. OSM #1 stated, "They [the wander guards] come with expiration dates and when that date comes up, I replace it and dispose of the old one." When asked if he had Resident #1's wander guard that was in place at the time of the fall, OSM #1 stated, "No, it was discarded. They do not keep them (wander guards] they are thrown away when they expire." When asked if he checks the functioning of the wander guards, OSM #1 stated he does not. OSM #1 stated he does audits once a month to check the expiration dates. When asked if he had documentation of these checks, OSM #1 stated if he puts it [his monthly audits of the wander guards] on paper, he gives it [the paper] to the DON (director of nursing). OSM #1 stated that most of the time he doesn't write it [his monthly wander guard audits] down, as "I just fix it as I go." When asked about Resident #1's wander guard, OSM #1 stated he is aware that he wears one. When asked if he knew when Resident #1's wander guard expired, OSM #1 stated, "He was contacted over the weekend to give a code to go in supply to get a new one." He stated that the company usually calls him and "tells him that some are about to expire and asks if I need to order more." When asked if the company had called him regarding Resident #1's wander guard expiring in June, OSM #1 stated they had not called. When asked for the manufacturer's

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information regarding how often the functioning of the wander guard is to be checked, OSM #1 stated he couldn't get through to the manufacturer to find that out.

On 6/15/2021 at 8:41 a.m. OSM #2, the maintenance director, was observed checking the alarm on Wing 3. The alarm functioned when he came near the door with an active wander guard.

On 6/15/2021 at 8:50 a.m., an interview was conducted with LPN #6, a nurse that responded to the incident regarding Resident #1 on 6/5/21. When asked what her involvement was with Resident #1's fall outside the main lobby doors, LPN #6 stated that she was working on Wing 2 and had just gone outside to let the transportation staff in with a new admission. She saw everyone at the front door and offered her assistance. LPN #6 stated, "Resident #1 was already in the wheelchair. (Name of RN #2) asked me to print the paperwork for Resident #1 for transport to the hospital. I went back and (RN #2) told me she didn't need it anymore. I went back to my unit (Wing 2)." When asked if she heard the wander guard alarm go off, LPN #6 stated, "She didn't." When asked if she would hear it on Wing 2, LPN #6 pointed to a box in the ceiling and stated it alarms here in the nurse's station.

On 6/15/2021 at 8:58 a.m., an interview was conducted with ASM #2, the interim director of nursing, regarding Resident #1 exiting the facility front doors and falling on 6/5/2021. ASM #2 stated, "The nursing supervisor called me and left me a message on 6/5/2021 that she wanted to update me and it could wait until the morning." ASM #2 stated she called her [the nursing supervisor] and was told what happened. ASM

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#2 stated she went into the facility. Spoke with their regular NP (who was on vacation and unavailable for interview during the survey) and got an order to send the resident out to the ER for evaluation. ASM #2 stated, "She was worried as Resident #1 was on Eliquis (Apixaban) and was told he had scrapes on his shoulder and had a goose egg on his head." ASM #2 stated she called the ER and gave report to them. She stated Resident #1 was returned to the facility. ASM #2 stated on 6/7/2021, she did not hear anything all day about (Resident #1), then in the evening she got a call that he had an x - ray that showed he had a fractured clavicle. ASM #2 stated, "She obtained a physician order to send the resident to the ER for evaluation and the resident returned to the facility with a sling on his arm." When asked if the facility did an investigation into the fall, ASM #2 stated they had. When asked the outcome of that investigation, ASM #2 stated she in-serviced the staff that weekend on how to check the wander guard functioning and placement. When asked if any other things were found, ASM #2 stated that the boxes to check the wander guards did not have functioning batteries in them. They found two of the four units had batteries that were dead. When asked if one of those boxes was on (the wing where Resident #1 resided on 6/5/21), ASM #2 stated, "Yes." ASM #2 stated, "We can't say when the wander guard stopped working but after the fall it was not functioning." ASM #2 stated, "They can't say when the batteries, in the box to check the wander guards, stopped working. They were not working at the time of the in-services she performed."

An interview was conducted with ASM #1, the administrator, on 6/15/2021 at 9:33 a.m. When

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asked her involvement in the incident with Resident #1, ASM #1 stated she was out of town that weekend. When asked if anyone came to the facility to check the wander guard system after Resident #1's incident, ASM #1 stated, No, only the maintenance director (OSM #2), he checks it [the wander guard system]. We can check the functioning ourselves."

On 6/15/2021 at 12:42 p.m., ASM #2 was asked if the facility had a policy on how to manage/maintain the wander guard system, ASM #2 stated no they do not. When asked if they had a policy on checking the wander guard functioning, ASM #2 stated, "No, they don't."

The facility policy, "Resident Elopement Policy" documented, "Purpose: To identify and intervene for those residents founds to be at risk for elopement. Documentation: For all residents in the facility. Procedure: 1. Any resident to be found to be at risk for elopement will have measures taken to attempt and prevent any such occurrences. 2. A wander guard bracelet will be place (sic) on arm or ankle or wheelchair of resident at risk. 3. An incident report will be completed and discussed with the interdisciplinary care plan team with any elopement attempts will care plan updated as needed. 3. If the risk of elopement exceeds the monitoring capabilities of the facility, alternative placement will be sought for the resident at risk."

A document presented on 6/15/2021 at 8:33 a.m. from OSM #1, entitled, "Wander Management Transmitters" documented in part, "The Adult transmitter is a lightweight and compact transmitter that is placed on the ankle or wrist of a resident and has a life expectancy of 1 1/2 or 2

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years for non-ID transmitters or 1 or 3 years for ID transmitted. Using a transmitter beyond the printed expiration date can results in system failure and/or elopement." There was no information to address checking the functioning of the transmitter. An email to OSM #1 from the company from which they purchase the wander guards from dated 6/15/2021 at 9:35 a.m. documented, OSM #1 wrote: "How often is it suggested to test the wander guard transmitters?" The company responded, "We don't have any official suggestion as far as how often, most customers set up their own procedures. That said, I know many customers test the transmitters at least weekly, if not more often."

ASM #1 and ASM #2 were made aware of the concern for harm regarding Resident #1 and his fall of 6/5/2021, on 6/15/2021 at 1:50 p.m.

No further information was provided prior to exit.

Complaint Deficiency

References:
(1) Stroke is an abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Hemiplegia is paralysis affecting only one side of the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

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(3) Atrial fibrillation a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html

2. The facility staff failed to implement Resident #7's fall mat per the comprehensive plan of care. During observations on 6/14/21 and 6/15/21, Resident #7 was observed in bed without a fall mat on the floor.

Resident #7 was admitted to the facility on 5/6/19. Resident #7's diagnoses included but were not limited to chronic kidney disease, anxiety disorder and dementia. Resident #7's quarterly minimum data set with an assessment reference date of 4/7/21, coded the resident's cognition as severely impaired. Section G coded Resident #7 as requiring extensive assistance of two or more staff with transfers.

Review of Resident #7's clinical record revealed a nurse's note dated 6/30/20 that documented the resident was observed sitting on the floor next to the bed.

Resident #7's comprehensive care plan, revised on 6/30/20, documented, "Resident is at risk for falls related to impaired mobility. Interventions/Tasks: low bed and floor mat..."

Resident #7's June 2021 physician order sheet did not contain an order for a fall mat.

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A fall risk assessment dated 4/1/21 documented Resident #7 presented with a low risk for falls.

On 6/14/21 at 11:32 a.m., 6/14/21 at 3:04 p.m. and 6/15/21 at 8:03 a.m., Resident #7 was observed lying in bed. During each observation no floor mat was observed on the floor by the resident's bed. A floor mat was observed across the room against the wall.

On 6/15/21 at 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #7 the nurse caring for Resident #7. LPN #7 was asked the process for ensuring fall interventions are implemented. LPN #7 stated that whenever the nurses get an order for placement of a fall mat, the nurses go to central supply and obtain the equipment. When asked if she would know that a fall mat should be implemented if there was no order but the intervention was on the care plan, LPN #7 stated she wouldn't know unless she sat in on the care plan meeting, received verbal report or unless the fall mat was documented in the huddle book (a communication book). LPN #7 stated Resident #7 was supposed to have one fall mat beside her bed every shift but staff picks up the mat during meals. LPN #7 stated the mat is supposed to be placed back down beside the bed when the meal is completed and the tray table is moved.

Note: no meal tray was observed on Resident #7's tray table during all observations on 6/14/21 and 6/15/21.

On 6/15/21 at 10:39 a.m., an interview was conducted with CNA (certified nursing assistant) #5, the CNA caring for Resident #7. CNA #5

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	495142	A. BUILDING _____ B. WING _____	C 06/15/2021

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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F 689	Continued From page 23 stated the nurses tell the CNAs who should have a fall mat. CNA #5 stated Resident #7 has a fall mat that is moved during meals and the mat is supposed to be placed back on the floor beside the bed after meals. When informed of the above observations, CNA #5 stated, "Unless it was busy. Honestly, I can't say." On 6/15/21 at 1:50 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy regarding falls and care plans documented, "To provide an environment that is safe and that minimizes the potential for resident injury due to falls. To identify fall risk factors particular to the individual resident that may be reduced through care planning and implementation of individualized interventions...6. Risk factors and fall management measures for individual residents will be documented on the residents' comprehensive care plan and communicated to the direct care staff for implementation." No further information was presented prior to exit.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	F842 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1 by reeducating nursing staff of importance of complete and accurate patient records, including the MAR and TAR in regards to resident's Wander Guard.	

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F 842	Continued From page 24 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	2. Current facility residents ordered a Wander Guard have the potential to be affected by the alleged deficient practice. A 100% audit of the MAR's and TAR's of residents ordered Wander Guards will be completed for accurate and complete documentation. Reeducation will be given to nurses in regards to missing documentation. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nursing staff to sign MAR and TAR in regards to Wander Guard per facility policy to maintain an accurate and complete record. A 100% audit of MAR and TAR for residents ordered Wander Guards will be completed weekly by the QA nurse/designee for 3 months to assure continued compliance. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report weekly to Risk Management Committee x 3 months. Any identified issues will be brought to the quarterly Quality Assurance committee meeting for six months to evaluate the effectiveness of the plan. The plan will be adjusted as the committee may recommend, based on any outcomes/trends identified. 5. Completion Date: July 5, 2021	

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F 842	Continued From page 25 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain an accurate clinical record for one of ten residents in the survey sample, Resident #1. The facility staff failed to accurately document checking the function and placement of Resident #1's wander guard. The findings include: Resident #1 was admitted to the facility on 5/10/2014 with a readmission on 8/23/2020 with diagnoses that included but were not limited to: stroke (1), hemiplegia (paralysis affecting only one side of the body) (2), history of falls, atrial fibrillation (3), dementia and fracture left clavicle (collar bone). The most recent MDS (minimum data set)	F 842		

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assessment, a quarterly assessment, with an assessment reference date of 3/12/2021, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for moving in the bed, transfers, locomotion on the unit, dressing, toileting, personal hygiene and bathing. Resident #1 was coded as requiring supervision after set up assistance was provided for eating. In Section E - Behaviors, the resident was not coded as having wandering behavior during the lookback period.

The physician order dated 8/23/2020 documented, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk."

Review of the TAR (treatment administration record) for May 2021 documented in part, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk." All boxes for all shifts for the month of May 2021, evidenced documentation of staff signatures as having checked placement and function every shift

The TAR for June 2021 documented in part, "Wander guard to LLE (left lower extremity), check placement and function every shift for elopement risk." All but two night shift boxes documented staff signatures from 6/1/2021 thru 6/13/2021, evidencing the checking of placement and function every shift.

An interview was conducted with LPN (licensed practical nurse) #2 on 6/14/2021 at 1:49 p.m.

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When asked who checks the functioning of the wander guard on Resident #1, LPN #1 stated the 11-7 (11:00 p.m. - 7:00 a.m.) shift nurse checks for function, I just check for placement, I don't check for functioning. When asked where the functioning check of the wander guard is documented, LPN #2 stated it is on the TAR.

An interview was conducted with RN (registered nurse) #1 on 6/14/2021 at 2:55 p.m. When asked how she checks the placement and functioning of a wander guard, RN #1 stated, "I was never taught to check the function of it. I know to check where it is." The TAR for June 2012 was reviewed with RN #1. RN #1 stated, "A nurse told me as long as I saw it on him, I could sign it off."

An interview was conducted with LPN #3 on 6/14/2021 at 3:51 p.m. When asked if you can sign off checking and completing something on the TAR if you didn't do it, LPN #3 stated you should only document it if you did what the order said.

A policy on documentation and an accurate clinical record was requested on 6/15/2021 at 12:42 p.m. from ASM (Administrative staff member) #2, the director of nursing.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current

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standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

ASM #1, the administrator, and ASM #2 were made aware of the above on 6/15/2021 at 1:50 p.m. A second request for the policy regarding accurate documentation and accurate clinical record was requested at this time.

The facility policy, "Accurate Clinical Documentation" documented in part, "Purpose: Provide guidance to accurate clinical documentation. Purposes of Nursing Documentation: Communication. Accountability. Legislative. Quality improvement. Research. Funding and resource management. Guidelines for nursing Documentation: Factual. Accurate. Complete. Organized. Timely. Clinical Picture: Anyone reviewing the charting must be able to see what happened or is being reported: what happened, to whom, by whom (while protecting privacy), when, why, the results of what happened, who was notified."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.