STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING ______ B. WING ______	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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 survey was conducted 7/27/21 through 7/28/21. One complaint was investigated during survey: VA00051031 was Substantiated with a related deficiency. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 138 certified bed facility was 90 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #101 through #104) and 4 closed record reviews (Resident #105 through #108).	F 000		
F 689 SS=D	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 staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to consistently implement fall interventions to prevent injury from falls for one of 8 sampled residents; Resident #101. The findings included: Resident #101 was admitted to the facility on 9/8/18 with diagnoses that included but were not	F 689	1. Resident #101's floor mat was placed at her bedside. 2. All residents with a history of falls have the potential to be affected. 3. DON or designee will inservice nursing staff on implementing fall interventions to prevent injury from falls and to keep environment free from accident hazards. Licensed staff will be educated on	7/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/13/2021

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 limited to Parkinson's Disease, muscle weakness, high blood pressure, osteroarthritis, unspecified psychosis, and vascular dementia. Resident #101's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/11/21. Resident #101 was coded as being severely impaired in cognitive function scoring 03 on the Staff Assessment for Mental Status Exam. Resident #101 was coded as being totally dependent on one staff with transferring, dressing, eating, personal hygiene, bathing; and extensive assistance from one staff with bed mobility. Resident #101 was coded as not having any recent falls since the last MDS assessment (5/31/21). Review of Resident #101's most recent "Morse Fall Scale" score dated 5/27/21, revealed that Resident #101 scored a level of 75- which indicated that she was a high risk for falls. The following was documented on her Morse Fall Scale report: "Has Resident ever fallen before: Yes. Does the resident have more than one diagnoses on the chart? Yes. Ambulatory Aid: None/bedrest/wheelchair/nurse assist. IV or IV Access: No. Gait: Impaired- difficulty rising from chair, uses chair arms to get up, bounces to rise. - Keeps head down when walking, watches the ground. -grasps furniture, person or aid when ambulating. Cannot walk unassisted. Mental Status: Overestimates or forgets limits." Review of Resident #101's fall incident reports revealed that her last fall was on 5/27/21 from her bed. The following was documented: "Resident found on floor in room face down on the right side of body in fetal position. Head on right side facing window with shoulder in direction of stand up	F 689	editing Kardex to update fall interventions. Certified staff will be educated on accessing Kardex to view fall interventions. 4. DON will audit fall interventions 2X/week for 4 weeks, then 1x/week for 4 weeks. The results of the audits will be reported to the facility's QAPI Committee monthly for 3 months. The QAPI committee is responsible for monitoring of the ongoing compliance.	

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F 689	Continued From page 2	F 689		

locker. Two female CNAs got resident off floor with Hoyer lift and placed resident in bed...No apparent injury."

Review of Resident #101's July POS (Physician Order Summary) revealed the following order: "Floor mat x 1 @ (at) bedside every shift for fall prevention." This order was initiated on 9/11/19.

Review of Resident #101's comprehensive care plan for falls dated 9/21/18 and revised on 5/27/21 documented in part, the following intervention: "...Floor mat x 1 at bedside." This intervention was implemented on 9/21/18.

On 7/27/21 at 11:30 a.m., a nursing aide (CNA (Certified Nursing Assistant) #1, was observed in Resident #101's room providing care. This aide left the room at 11:35 a.m. Resident #101's fall mat was pushed against her roommate's bed and not in place.

On 7/27/21 at 1:45 p.m., Resident #101 was observed sitting up in bed. Her fall mat was still pushed to the side up against her roommate's bed.

On 7/27/21 at 2:35 p.m., Resident #101 was observed sitting up in bed. Her fall mat was still pushed to the side up against her roommate's bed.

On 7/27/21 at 3:00 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #101's nurse. When asked if Resident #101 was a fall risk, LPN #2 stated that this was her first time working with the resident as she was an agency nurse. LPN #2 stated that Resident #101 needed extensive assistance for

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F 689	Continued From page 3 mobility so she would gather that Resident #101 was not a fall risk. LPN #2 stated, "She doesn't try to get out of the bed." When asked if Resident #101 needed anything in place to prevent injuries from falls, LPN #2 stated that she was not sure; that she had to check. When asked where she would check, LPN #2 stated that she believed she saw an order for a fall intervention but wasn't sure if it was for Resident #101. LPN #2 checked Resident #101 chart and stated that Resident #101 had an order for a fall mat to one side of the bed. LPN #2 stated that the fall mat was in place that morning when she had checked and signed off on the order. When asked if the fall mat was in place now, LPN #2 stated that she was not sure. This writer then followed LPN #2 to Resident #101's room. LPN #2 stated that the mat was down but that it was next to the roommates bed rather than her own bed. LPN #2 stated that staff sometimes provide care and feeding assistance to Resident #101 and that staff must have forgot to put the fall mat back. When asked if the fall mat was benefiting Resident #101 at all being next to the roommate's bed, LPN #2 stated that it was not. When asked if she expected staff to put the fall mat back in place after care was rendered, LPN #2 stated, "Yes." When asked who was responsible for ensuring fall/safety interventions were in place for each resident, LPN #2 stated that all staff were responsible. On 7/27/21 at approximately 3:30 p.m., Resident #101's nursing Kardex; a care plan used by the nursing aides was requested. On 7/27/21 at 4:05 p.m., LPN #1, the unit manager explained to this writer that the nursing Kardex could not be printed but that the nursing aides had access to the Kardex on PCC (Point Click Care). LPN #1 stated that there was no way for her to update the	F 689		

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F 689	Continued From page 4 Kardex anymore since they changed companies. LPN #1 pulled up Resident #101's nursing Kardex and a fall mat was not on her Kardex. When asked how CNAs are made aware of what interventions need to be in place for each resident if the Kardex cannot be updated, LPN #1 stated that nurses usually give all nursing aides a verbal report and if the nursing aides see a fall mat on the floor, they should know the resident requires a fall mat. On 7/28/21 at 10:42 a.m., ASM (Administrative Staff Member) #1, the Executive Director and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Fall Prevention Program," documents in part, the following: "Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive care plan. a. Interventions will be monitored for effectiveness. The plan of care will be revised as needed." COMPLAINT DEFICIENCY	F 689		