

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/30/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/08/2022
NAME OF PROVIDER OR SUPPLIER EMPORIA REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEAVER AVENUE EMPORIA, VA 23847		
(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 on 06/08/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00055365 - substantiated) was investigated during the survey. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000			
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 staff interviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to mitigate a known accident hazard for one Resident (Resident #1) in a survey sample size of 4 Residents. Specifically, Resident #1 needed assistance and guidance with dressing and had a known behavior of holding her dialysis catheter and picking at the dialysis catheter dressing. On the morning of 05/27/2022, Resident #1 was not assisted with dressing and found half-dressed, lying across the bed, no dressing on the dialysis catheter site, and one of the port caps removed resulting in Resident #1's	F 689	F689: Free of Accident Hazards/Supervision/Devices 1. Incident on 05/27/2022 cannot be retroactively corrected for Resident #1. 2. All dialysis residents are at risk for being affected by this deficient practice. Risk assessment done on all dialysis residents to include behaviors related to dialysis access site. Dressing protocol reviewed. No dialysis resident currently presents a behavior problem related to	7/7/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/24/2022

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	<p>Continued From page 1</p> <p>death by exsanguination (severe loss of blood). This is harm.</p> <p>The findings included:</p> <p>On 06/08/2022, Resident #1's closed clinical record was reviewed. Resident #1's most recent Minimum Data Set with an Assessment Reference Date of 05/03/2022 was coded as a Significant Change in Status assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Functional status for dressing was coded as requiring limited assistance from staff meaning the resident was highly involved in activity and the staff provided guided maneuvering of limbs or other non-weight-bearing assistance with a one person physical assist.</p> <p>A review of the progress notes for April and May 2022 revealed that Resident #1 was admitted to the hospital on 04/21/2022 due to multiple abscesses on the left arm and returned to the facility on 04/26/2022 with a double lumen catheter in the right internal jugular (IJ) for dialysis access.</p> <p>A physician's order dated 05/03/2022 documented "Check access right double lumen IJ [internal jugular vessel] for bleeding, redness, tenderness, and swelling." The Treatment Administration Record associated with this order was signed off as administered on the night shift 05/26/2022 and on the day shift 05/27/2022.</p> <p>Resident #1's care plan was reviewed. The care plan did not document any behaviors pertaining to touching the dialysis catheter or disrupting the dressing.</p>	F 689	<p>the dialysis access. Dressing has been enhanced to include gauze pad over catheter site secured with paper tape and dialysis catheters are wrapped in kling gauze and secured with paper tape. Cognitively impaired dialysis residents will be encouraged to wear a high collared t-shirt/clothing to discourage easy access to the dialysis site.</p> <p>3.Licensed nursing staff will be re-educated by Nurse Management on hemodialysis access care, to include observing if dressing is in place, dry, and secure. Certified Nursing Assistants will be re-educated to report if dressing is not in place, wet, bleeding or not secure or resident shows signs of tampering with dialysis access site. Licensed nursing staff as well as Certified Nursing Assistants will be educated on the use of a high collared t-shirt/clothing to discourage easy access to the dialysis site.</p> <p>Licensed nursing staff will monitor dialysis dressing 6 times in a 24 hour period on cognitively impaired residents.</p> <p>Hemostat and dressing change supplies will be kept at the bedside of each dialysis resident as well as at each medication and treatment cart.</p> <p>Dialysis residents' orders updated to reflect the proper dialysis access care.</p> <p>Residents currently on dialysis will be careplanned appropriately.</p>		

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F 689	<p>Continued From page 2</p> <p>A progress note dated 05/27/2022 at 7:10 A.M. documented, "Resident noted in bed asleep at present time. No distress noted."</p> <p>A progress note dated 05/27/2022 at 10:10 A.M. documented, "CNA yelled for this writer to come to room [number]. Resident noted on bed on back with legs hanging off bed. Resident has pants on but no shirt noted on resident. Large pool of bright red blood noted on bed surrounding resident. Bright red blood noted on floor. Dialysis double lumen catheter noted in right chest wall. No active bleeding noted from dialysis catheter. Blue cap from dialysis catheter noted beside resident. Checked carotid and radial pulse. Resident is a DNR. No pulse noted. No signs of life. Resident is pale and warm to touch. Ask floor tech supervisor to call nurses to [name of unit]. Central nurse RN arrive to access resident. All other facility nurses arrived to room to assist. DON informed of incident. NP informed of incident. Family called by Central nurse. They stated to call [name] funeral home. 911 called per protocol. EMT arrived stated that they spoke with [physician name] and he pronounced resident death at 0853. Funeral home called and body was release [sic] to them upon their arrival."</p> <p>On 06/08/2022 at approximately 3:15 P.M., CNA B working on the Memory Care unit was interviewed. CNA B verified they worked with Resident #1 the day before the incident on 05/27/2022. When asked about Resident #1's functional status for dressing, CNA B stated that Resident #1 needed assistance getting dressed but would, at times, get herself dressed. When asked if Resident #1 had any behaviors associated with the dialysis catheter, CNA B</p>	F 689	<p>4. Weekly audit X 4 weeks, monthly audit X 2 months will be done by Director of Nursing or designee to ensure dressing is in place, the emergency kits are in designated areas, licensed nursing staff are monitoring dressing site 6 times in a 24 hour period on cognitively impaired residents.</p> <p>Dialysis residents will be reviewed during weekly Risk Meeting to ensure continued POC compliance on current and new dialysis residents.</p> <p>Director of Nursing or designee shall present results of audits to monthly QAPI meetings X 3 months.</p>		

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F 689	<p>Continued From page 3</p> <p>stated that Resident #1 would "mess with it." CNA B stated if Resident #1 took notice of the catheter, she would hold it. CNA B stated that the day before the incident on 05/27/2022, CNA B observed Resident #1 holding the dialysis catheter. CNA B stated that they (1) told Resident #1 not to touch it and that Resident #1 was easily redirected. When asked if this was reported to the nurse, CNA B stated they did report it to the nurse but they could not remember the nurse's name because it was an agency nurse. When asked about the dressing for the dialysis catheter, CNA B stated that the site would usually have a dressing but the tubing was not wrapped.</p> <p>On 06/08/2022 at 3:45 P.M., LPN D was interviewed. LPN D verified she was an agency nurse working at the facility for the past three months. LPN D verified she was the nurse working with Resident #1 on the day of the incident. LPN D stated that Resident #1 could dress herself. When asked about the dialysis catheter dressing prior to the incident, LPN D stated usually the site was dressed but the tubing was not wrapped. LPN D stated that usually the tubing, the clamps, and the caps could be seen. LPN D stated Resident #1 had a double lumen dialysis catheter; one lumen with a red cap; one lumen with a blue cap. When asked about Resident #1's behaviors pertaining to the dialysis catheter, LPN D stated she personally did not ever see Resident #1 "messing with" her dialysis catheter.</p> <p>On 06/08/2022 at 4:25 P.M., CNA E was interviewed. CNA E verified she discovered Resident #1 on the morning of the incident on 05/27/2022. CNA E verified she was assigned to care for Resident #1 that day. CNA E stated that</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>she got into work an hour late that day. CNA E stated she did call to let someone know she would be late but could not recall the name of the person she notified. CNA E stated that when she arrived on the unit, other staff members were passing breakfast trays so she also started passing trays. CNA E stated that 7:56 A.M., she entered Resident #1's room with the breakfast tray and found Resident #1 lying across her bed with blood all around.</p> <p>On 06/08/2022 at 4:35 P.M., the Director of Nursing (DON) was interviewed in the conference room with Surveyor B and Surveyor C present. When asked if the incident involving Resident #1 on 05/27/2022 was investigated, the DON stated it was investigated. When asked about the findings of the investigation and any changes made as a result of the investigation, the DON stated that all Residents with dialysis catheters were checked to ensure the dialysis catheter site was secured with gauze and tape. The DON stated that the "orders were revamped" to include calling the dialysis center if the dialysis catheter didn't have a dressing on. Also, the facility staff placed hemostats [a clamp] and dressing supplies at the bedside of all Residents with a dialysis catheter "in case something was to happen and they needed something right then." When asked if staff received any education related to the incident, the DON stated that "nurses and some aides" received education to report it if the dialysis dressing is off. When asked for the in-service sheets, the DON stated that she remembers educating everyone but did not recall having them sign in-service sheets. When asked if Resident #1 had a dressing on her dialysis catheter the morning of the incident, the DON stated that Resident #1 did not have a dressing</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>on that morning. The DON stated she checked the eMAR (electronic Medication Administration Record) and it was "checked off as on there." The DON indicated that at some point, the dressing came off. When asked if Resident #1 had behaviors of touching her dialysis catheter or disrupting the dressing, the DON stated that Resident #1 would mess with it at times and the staff would remind her not to mess with it. The DON stated that Resident #1 would pick at the tape and the dressing.</p> <p>On 06/08/2022 at approximately 5:30 P.M., the administrator and DON were notified of findings. At approximately 6:15 P.M., the DON provided a copy of a written statement, signed by the DON, dated 06/08/2022 which documented the following excerpt: "I was not made aware of resident's behavior of "picking" at her dialysis catheter site until the date of this incident."</p> <p>On 06/08/2022, the facility staff provided a copy of their policy entitled, "Hemodialysis Access Care." Under the header, "Care immediately following dialysis treatment" in Section (1) and (2) documented, "The dressing change is done in the dialysis center post-treatment. If dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. (Note: Check with State Nurse Practice Act to determine licensure and competency requirements)."</p> <p>(1) Singular "they" (a generic third-person singular pronoun) is being used to protect anonymity. See https://apastyle.apa.org/style-grammar-guidelines/grammar/singular-they</p>	F 689			