STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495270	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEMONT HEALTH & REHAB CENTER, LLC	3750 SENTARA WAY VIRGINIA BEACH, VA 23452

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 08/09/22 through 08/11/22. Significant corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Past Non-Compliance was granted for the deficiency cited. Two complaints were investigated during the survey. The census in this 116 certified bed facility was 92 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3.)	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 a clinical record review, resident interview, staff interviews, facility document review and during the course of a complaint investigation the facility failed to ensure 1 of 3 residents (Resident #1) in the survey sample was free from an avoidable fall from the bed during the provision of incontinent care that required an emergency room evaluation and hospital admission of a subsequent impacted left femur fracture, resulting in harm, Resident #1.	F 689	Past noncompliance: no plan of correction required.	

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

Administrator | 9/01/22

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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The facility staff failed to ensure extensive two person staff assist was provided during incontinent care to Resident #1 on 12/16/21. As a result, Resident #1 fell out of the bed and onto the floor. The resident sustained an impacted left femur fracture requiring hospitalization.

The findings included:

Resident #1 was originally admitted to the facility on 12/13/2017 and readmitted on 12/19/21 with diagnoses to include but not limited to spastic hemiplegia of the left side and left femur neck fracture.

Resident #1's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 7/28/22. The resident's Brief Interview for Mental Status (BIMS) was coded as an 8 out of a possible 15, indicating the resident was moderately cognitively intact and capable of some daily decision making. Under Section G Function Status, Resident #1 is coded as requiring total dependence 2 person physical assist for toileting.

Resident #1's MDS with an ARD of 9/28/21 was also reviewed. The Brief Interview for Mental Status was coded as a 12 out of 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section G Function Status, Resident #1 was coded as requiring total dependence 2 person physical assist for toileting.

Resident #1's Fall Risk Assessment dated 10/1/21 was reviewed and indicated the resident was a high fall risk with a score of 14.

Resident #1's Comprehensive Care Plan last

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revised 8/3/22 was reviewed and is documented as follows:
"...Focus: Resident has self-care deficit. Two person assist for toilet use. Date Initiated: 9/28/21..."

Resident #1's Progress Notes for 12/16/21 were reviewed and revealed that at 4:30 a.m. the Certified Nursing Assistant (CNA) was providing incontinent care to the Resident #1 while in bed. The CNA turned the resident to the right side and she rolled over onto the floor. Upon assessment Resident #1 complained of left hip and left arm pain of an 8 out of 10 on the pain scale. Stat x-rays were obtained which identified an impacted left femur fracture and the resident was sent to the emergency room and admitted to the hospital that same day.

Resident #1's Hospital Discharge Summary dated 12/19/21 was reviewed. The Hospital Discharge Summary indicated that the Resident #1 stated she was getting changed by the nurse at the facility and she rolled off the bed. The Resident was admitted with an impacted left femur fracture.

On 8/9/22 at approximately 11:30 a.m. an interview was conducted with Resident #1 regarding her fall and fractured hip on 12/16/21. Resident #1 stated that the CNA was providing incontinent care that morning by herself and when she rolled her over she fell right out of the bed on to the floor and broke her hip.

On 8/10/22 at 8:25 a.m. a phone interview was conducted with CNA #2 regarding Resident #1's fall on 12/16/21. CNA #2 told the surveyor that she went in the change Resident #1 around 4:30

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a.m. and that the resident was very contracted in both of her legs. CNA #2 stated that she pulled Resident #1 towards her with the sheet and rolled her over on her right side and that the resident was moving all over the bed. CNA #2 said she reached back to grab some wipes from the bedside table and the resident stated to slide off the bed. The CNA also stated that she tried to hold on to the resident and was able to ease her head to the ground but from the waist down she had already hit the floor. CNA #1 stated that she was not aware that Resident #1 required 2 person assist for toileting but looking back now she should have had another person helping her.

On 8/10/22 at 8:50 a.m. a phone interview was conducted with Licensed Practical Nurse (LPN) #2 regarding Resident #1's fall on 12/16/21. LPN #2 stated she was passing medications down the hall and that CNA #2 came out into the hall hollering for her to come to Resident #1's room. LPN #2 stated that when she walked into the room Resident #1 was on the floor beside the bed and complaining of pain. LPN #2 also said that CNA #2 told her that she was changing the resident and when she rolled her over the resident fell out of the bed.

On 8/11/22 at 10:38 a.m. an interview was conducted with the Director of Nursing (DON) regarding Resident #1's fall from her bed on 12/16/21. The DON stated that CNA #2 did not have another staff member assisting her while providing incontinent care to Resident #1 on 12/16/21, which resulted in the resident falling out of the bed and fracturing her hip. The DON also stated Resident #1 was harmed because she fell and fractured her hip and that she did not receive the 2 person assist that she was care planned for.

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The facility policy titled "Fall Prevention and Management Policy" last revised 12/9/19 was reviewed and is documented as follows:

"...Policy: If risks are identified, preventive measures will be put in place and care planned. All falls will be reviewed and investigated..."

"...Procedure: Individualized interventions will be implemented based on the assessment and care planned accordingly..."

On 8/11/22 a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services where the above information was shared.

Upon entrance the facility provided a Quality Assessment and Performance Improvement Action Plan with a start date of 12/16/21. The allegation of compliance date was 2/7/22. The facility is requesting past non-compliance. The plan stated the facility failed to follow fall protocols, ensure fall interventions were followed and CNA's were competent in the handling of residents. The facility reviewed all falls from the previous 30 days to ensure all falls interventions and care plans were updated. The facility provided education to all licensed nurses (agency included) on the fall policy and protocols, interventions and updating the care plan. The facility staff was also educated and competencies were completed with CNA's on the proper transfer and handling of residents. The DON/designee is to audit fall process in the clinical meeting daily for appropriate interventions and care plan updates 5 times a week for 6 weeks. Facility audits were reviewed with no

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F 689	Continued From page 5 issues identified. Facility nursing staff were interviewed on all units and verbalized training on the above stated issues and how they will respond hence forth. The facility conducted a QAPI (Quality Assurance and Performance Improvement) meeting on 12/20/21 with all required attendees present. During the survey no current residents were identified in the sample with the above deficient practice. After the facility's Quality Assessment and Performance Improvement Action Plan, training documents and audits were reviewed it was determined that the facility was in compliance as of 8/10/22. Prior to exit no further information was shared. This is a Complaint Deficiency.	F 689		