STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEDALE HEALTH & REHABILITATION	1719 BELLEVUE AVENUE RICHMOND, VA 23227

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 10/10/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey (VA00059805- substantiated with deficiency). The census in this 128 certified bed facility was 106 at the time of the survey. The survey sample consisted of three current resident reviews and three closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence neurological assessment and monitoring after an unwitnessed fall with head injury for one of six residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to evidence neurological check (1) monitoring after	F 684	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have¿been made and the facility is in compliance with participation requirements. 1. Resident #1 has been evaluated by the physician/nurse practitioner. Resident #1 had no adverse reaction as a result of the unwitnessed fall with documentation of an injury to the forehead on 9/2/23.	11/3/23

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

Electronically Signed | 10/23/2023

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F 684	Continued From page 1 an unwitnessed fall with documentation of an injury to the forehead on 9/2/2023. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/28/2023, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The assessment documented no falls during the assessment period. On 10/10/2023 at 11:57 a.m., an observation was made of R1 in their room. An interview was attempted with R1 but was not able to be conducted due to their cognition level. R1 was observed in bed with the bed in the lowest position and the call bell within reach. When asked about the fall on 9/2/2023, R1 did not respond appropriately to the question. The progress notes for R1 documented in part, - "09/02/2023 11:15 (11:15 a.m.) Note Text : Resident had unwitnessed fall in bathroom with injury. He refused to go to the ER (emergency room) and insisted he was fine. He joked about having a hard head and stated, "...my friends are going to love this. Look what I can do when I get mean!" He allowed me to take his vitals at the time of the incident but then again only once about 2 hours later. Vitals are as follows: (1)152/91 (blood pressure), 86 (pulse), 20 (respirations), 98% (oxygen), 97.6 (temperature) (2)147/83 (blood pressure), 80 (pulse), 18 (respirations), 97% (oxygen), 97.7 (temperature). Hospice was contacted and they said to continue to monitor him. If there was any change of condition, contact them. He has no c/o (complaints of) pain at this time. Denies dizziness	F 684	2. An audit was performed to identify all residents with an unwitnessed fall or a fall that resulted in resident hitting head in the last 72 hours to ensure a neurological check was done appropriately. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding conducting neurological checks. The in-service includes, but is not limited to, the importance of conducting neurological checks if a resident hits head or has an unwitnessed fall and where to document the neurological check. 4. The Director of Nursing/designee will conduct an audit weekly for 4 weeks and monthly for 2 months of residents with unwitnessed falls or falls that result in resident hitting their head to ensure neurological checks are conducted appropriately. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 11/3/23	

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or nausea."
- "09/02/2023 21:52 (9:52 p.m.) Note Text : Resident f/u (follow up) fall. No bruising or swelling to forehead noted. Denies pain or discomfort from fall. 136/80 (blood pressure), 84 (pulse), 18 (respirations), 98.3 (temperature), 02 sat (oxygen saturation) 98% RA (room air)."
- "09/03/2023 06:54 (6:54 a.m.) Note Text : Post fall, no voiced complaints and no c/o pain. Resting quietly in bed. 98.2 (temperature)-89 (pulse)-18 (respirations) 156/78 (blood pressure), o2 sats 98%."
- "09/04/2023 06:31 (6:31 a.m.) Note Text : Post fall, no c/o pain, resting quietly in bed with eyes closed. 97.9 (temperature)-76 (pulse)-18 (respirations) 138/74 (blood pressure), o2 sats 98%."
- "09/06/2023 15:31 (3:31 p.m.) ... Small abrasion to left forehead. No change in LOC (level of conscious), mental status or cognition. Refused to go to hospital..."

The comprehensive care plan for R1 documented in part, "(Name of R1) is at risk for falls, had an actual fall r/t (related to) muscle weakness. Date Initiated: 08/01/2023. Revision on: 09/07/2023."

On 10/10/2023 at 12:42 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for evidence of neurological monitoring for the unwitnessed fall on 9/2/2023.

On 10/10/2023 at 1:40 p.m., ASM #2 stated that they were unable to find any evidence of neurological checks for the requested fall for R1. She also stated that the LPN (licensed practical nurse) who documented the progress note regarding the fall on 9/2/2023 no longer worked at

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the facility and that CNA (certified nursing assistant) #1 worked with R1 on 9/2/2023 the day of the fall.

On 10/10/2023 at 2:30 p.m., an interview was conducted with LPN #1. LPN #1 stated that when a resident had an unwitnessed fall the nurse went in and assessed the resident. She stated that they attempted to find out what happened and notified the physician and the family. She stated that they completed a risk management report which guided the nurse to complete a fall risk assessment, a progress note, neuro checks and other required documentation. She stated that they reviewed the care plan and updated it with any new interventions as necessary. She stated that an unwitnessed fall or a fall with head injury required the nurses to perform neuro checks per the facility protocol for 72 hours. She stated that the nurses used a paper form which had the instructions on how they were to be obtained during the 72 hours. She stated that she was aware that R1 had fallen in the bathroom and had refused to go out to the hospital to get checked and she would have expected for neuro checks to have been done after the fall.

On 10/10/2023 at 1:44 p.m., an interview was conducted with CNA #1. CNA #1 stated that R1 had told her that they had fallen in their bathroom but they did not think that they were working that day. She stated that R1 required supervision with toileting prior to their most recent hospitalization.

On 10/10/2023 at 4:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they were not working the day of R1's fall. She stated that when a resident had an unwitnessed fall or if they hit their head the

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nurses followed a neuro check protocol. She stated that residents were monitored for 72 hours following the neuro check flowsheet and they assessed the residents pupils, hand grasps, orientation, range of motion, speech and vital signs.

The facility policy "Fall Protocol" undated, documented in part, "... Actual Fall... 3. The resident will be monitored for change in condition q (every) shift for 72 hours; unless otherwise ordered by the physician/practitioner. a. Monitoring may include physical assessment of the resident, vital signs, neurological checks [if resident hit head or fall was unwitnessed], assessment for pain, swelling, redness, or impaired skin..."

The facility "Neurological Evaluation Flow Sheet" dated 6/20, documented in part, "Directions: Complete neurological evaluation with vital signs initially, then every 30 minutes x 4, then every hour x 4, then every 8 hours x 9 (72 hours)...Level of Consciousness...Orientation...Pupils...Motor Movement Evaluation...Communication/Language...Unusual/ New Observations...Vital Signs..."

On 10/10/2023 at 4:49 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

(1) Neuro checks

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F 684	Continued From page 5 "neuro-checks"-a series of quick questions and tasks that help healthcare providers assess how well a TBI patient's brain and body are working-some in-depth tests help reveal levels of injury or damage in TBI patients. This information was obtained from the website: https://www.nichd.nih.gov/health/topics/tbi/conditioninfo/diagnose	F 684		