STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495085	A. Building B. Wing	05/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View on the Appomattox Health & Rehab Center	201 Epps Street Hopewell, VA 23860

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to review and revise the care plan after each assessment or change in Resident condition for 1 Resident (#2) in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to review/revise the care plan to add additional interventions after the Resident fell while left unattended in the bathroom. A review of the clinical record revealed that Resident #2 did have a fall in her bathroom on 3/8/24 at 3:00 PM. A review of the progress notes revealed the following: 3/8/24 3:00 PM -Note Text: Resident is alert and verbal this writer heard resident calling out into the hall. When entering room resident was noted to be sitting on the floor on her buttocks in her bathroom. Resident stated she was using the bathroom and stood up but when she stood up [sic], she felt dizzy and fell forward onto her knees. Right Knee is red in color and warm ROM [range of motion] WNL [within normal limits]. Resident was hoyered into her wheelchair MD in facility made aware and gave new order to obtain x-ray of r knee r/t pain. Resident is own RP [responsible party] and made aware. On 5/15/24 the facility submitted a copy of the fall investigation excerpts are as follows: Location of fall - Bathroom (resident room) Conditions -Check ALL conditions that may have impacted THIS fall. Dizziness [box checked] History of falls in past 6 mos. [box not checked in spite of history of 2 falls at hospital prior to admission], Psychoactive medication - [box not checked in spite of Resident having orders for amitriptyline at bedtime, as well as Buspar twice per day and PRN alprazolam for anxiety], Recent medication change [box unchecked in spite of having Buspar and Alprazolam newly prescribed on 3/6/24], ambulating without needed help [box unchecked in spite of diagnosis of muscle weakness, difficulty walking, fibromyalgia, lack of coordination]. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Impact of fall - Check ALL outcomes that resulted from this fall. No boxes checked, however Resident #2's right knee was described as red, and the Resident complained of Right knee pain at time of fall. Resident Interview 3. Did you experience any of the following symptoms just prior to fall? Lightheadedness, slurred speech, Irregular heart rate, shortness of breath, Numbness, Dizziness Strange smell, Flashing lights, or other unusual symptoms? Yes Dizziness 6. How did you fall what were you trying to do? Go to bathroom Care Plan / Individualized Service Plan (ISP) Review: Educated to call for assistance r/t [related to] dizziness w/toileting. [Signed by nurse on 3/8/24 signed by Quality Review on 3/11/24] A review of the Fall Prevention Program page 2 Paragraph #7 read: When any patient experiences a fall, the Center will: a. Assess the patient. b. Complete a post fall assessment. c. Complete an incident report. d. Notify the physician / physician extender and legal representative / family. e. Review the patient's care plan and update as indicated. f. Document all assessments and actions g. Obtain witness statements in the case of injury. On 5/15/24 a review of the care plan revealed the following with regard to falls: FOCUS: (Resident #2 name redacted) is at risk for falls Date initiated: 2/11/24 GOAL: Will not sustain an avoidable fall or injury through the next review period Date initiated 2/11/24 INTERVENTIONS: Assess fall risk per facility protocol and implement appropriate measures. Reassess per protocol and as needed. Date initiated 2/11/24. Orient patient and family to room, call bell, lighting, and bathroom encourage to call for assistance. Date initiated 2/11/24. A review of the care plan policy revealed the following excerpt: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Planning Process - CP 102 Page 1 Paragraph #3 Additionally, the care plan is a fluid document and shall be reviewed and updated at any time the resident, family or representative or member of the ID team determines a need for additional interventions or care areas to be addressed. On the afternoon of 5/15/24 an interview with LPN C was conducted and she stated, When there is a fall, we first assess for injuries get vitals, assist them back to bed, then we do the post fall assessment and notify the family and the physician and document everything in the notes. When asked if the care plans should be updated after a fall, she stated that the care plan should be reviewed, the actual fall should be added along with new interventions. On 5/15/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to provide care that meets professional standards of quality for 1 Resident (#2) in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to obtain vital signs every 4 hours as ordered on 3/5/24. On 5/15/24 a review of the clinical record revealed a progress note from the Nurse Practitioner on 3/5/24 excerpts read: [Resident #2 name redacted] is being seen in follow-up today for shortness of breath with hypoxia, chest pain, and for vertigo. The resident reports that she is having more shortness of breath and dyspnea on exertion with task that would normally cause no shortness of breath. She reports that her oxygen saturations have been dropping when she sleeps. PLAN: The resident will start supplemental oxygen ATC [Around the Clock] at 2 L/min via nasal cannula. The nursing staff will monitor her for ongoing hypoxia, increased shortness of breath, PND [Paroxysmal Nocturnal Dyspnea], orthopnea, chest congestion, and wheezing. A review of the clinical record revealed that on 3/5/24 the the orders for vital signs monitoring was increased to every 4 hours. On 5/15/24 a review of the MAR (Medication Administration Record) revealed the vital signs were recorded identically on several occasions excerpts are as follows: On 3/6/24 at 2 a.m., 6 a.m., 10 a.m. and 2 p.m. the vital signs were recorded as: Blood pressure 144/82, Temp. 97.4, Pulse 90, Respiration 22, Oxygen Saturation 90% On 3/6/24 at 6 p.m., and 10 p.m., the vital signs were recorded as : Blood pressure 136/74, Temp. 97.1, Pulse 82, Respiration 18, Oxygen Saturation 96%. On 3/7/24 at 6 a.m., 10 a.m., 2 p.m., 6 pm and 10 p.,m. the vital signs were recorded as: Blood pressure 118/84, Temp. 97.3, Pulse 88, Respiration 20, Oxygen Saturation 90%. On 3/8/24 at 6 a.m., 2 a.m., and 6 a.m. the vital signs were recorded as: Blood pressure 134/86, Temp. 97.1, Pulse 95, Respiration -20, Oxygen Saturation 94% On 3/9/24 at 2 a.m. and 6 a.m. the vital signs were recorded as : Blood pressure - 129/85, Temp. 96.8, Pulse - 84, Respiration -18, Oxygen Saturation 93% (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/9/24 at 10 p.m. and 3/10/24 at 2 a.m. and 6 a.m. vitals were recorded as: Blood pressure 129/87, Temp. 97.4, Pulse 76, Respiration 20, Oxygen Saturation 95% **Note : Vital signs fluctuate normally during the day and night factors that affect the vital signs are positioning, stress, sleep, pain, anxiety, infection, medications and the normal homeostasis of the body reacting to ambient temperature. It would be extremely rare to find the all of the vital signs exactly the same twice in a row.** According to the National Institutes of Health / National Library of Medicine website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6333367/ Vital signs, i.e. respiratory rate, oxygen saturation, pulse, blood pressure and temperature, are regarded as an essential part of monitoring hospitalized patients. Changes in vital signs prior to clinical deterioration are well documented and early detection of preventable outcomes is key to timely intervention. On 51524 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unecessary medications for 1 Resident (#2), in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to follow physicians orders resulting in Resident #2 receiving meclizine after the Nurse Practitioner had ordered it discontinued. On 5/15/24 a review of the clinical record revealed the following excerpt from the NP (Nurse Practitioner) progress note. Date of Service: 02/27/2024 12:00 AM - The nursing staff will arrange an appointment for the resident to be evaluated by pulmonologist. The order has been placed. The nursing staff will monitor her for chest congestion, wheezing, and hypoxia. Vertigo-the resident has requested her meclizine be discontinued. It will be discontinued at this time. A review of the MAR (Medication Administration Record) revealed that although the physician put in her orders that the medication would be discontinued it was not stopped. Resident #2 continued to get the medication until 3/10/24. On 5/15/24 an interview with LPN B was conducted and she stated that when a physician orders a medication to be discontinued, they put it in the system so that it is no longer given to the patient and so that pharmacy can know not to send the medication. When asked if doctors put in the orders to discontinue, she stated that sometimes they do. On 5/15/24 a during the end of day meeting the Administrator was made aware of the concerns with medication administration and no further information was provided.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to provide timely diagnostic services to meet the needs of 1 Resident, (#2) in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to obtain a diagnostic sleep study as ordered by the discharging hospital prior to admission and again ordered by the Nurse Practitioner on 3/6/24 after a hypoxic episode at the facility. Resident #2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to chronic obstructive pulmonary disease, with acute exacerbation, long term use of insulin, fibromyalgia, hyperlipidemia, asthma with acute exacerbation, hypertensive heart disease with heart failure, morbid obesity, OSA (Obstructive Sleep Apnea), type 2 diabetes, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. On 5/14/24 a review of the clinical record revealed that Resident #2 had written discharge orders with the following excerpts: Follow up with [name of pulmonologist redacted] on 2/22/24 at 11:15 AM. Obtain outpatient sleep study. A review of the progress notes for 2/22/24 did not mention the Resident leaving the facility for a doctor appointment nor did it mention the appointment being canceled. On the afternoon of 5/14/24 an interview was conducted with the scheduler (employee D) and the Administrator. Employee D was asked the process for making appointments and transportation arrangements to outside appointments. Employee D stated that upon admission the nurses get the discharge summary and make the appointments then they fill out a Transportation slip and give it to employee D for her to arrange the transportation. When asked the process if the Resident already has the appointment scheduled she stated that the nurse confirms the appointment and puts in Transportation Slip so that she can schedule transportation. When asked if this process took place for Resident #2's appointment on 2/22/24, she stated that she could not find it in her book. She stated that she thought maybe the family might have taken Resident #2 or the appointment might have been canceled. The Administrator then asked, Wouldn't we have some kind of documentation that it was canceled? Employee D responded that the nurses were supposed to document any changes to the appointment. On 5/15/24 at approximately 10 AM the Administrator provided documentation that the Resident was unwell, and the appointment had been canceled due to gastrointestinal issues. A review of the clinical record revealed a progress note from the Nurse Practitioner on 3/5/24 excerpts read: (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident #2 name redacted] is being seen in follow-up today for shortness of breath with hypoxia, chest pain, and for vertigo. The resident reports that she is having more shortness of breath and dyspnea on exertion with task that would normally cause no shortness of breath. She reports that her oxygen saturations have been dropping when she sleeps. The resident reports that she was tested for obstructive sleep apnea several years ago, however she tested negative. Per her medical record however, she was diagnosed with obstructive sleep apnea. She reports no use of CPAP. The resident reports she has been on steroids for the last 3 months and has gained over 50 pounds. Plan: . Will have stat labs drawn to assess for abnormalities. The resident will also have a stat EKG [Electrocardiogram] performed to rule out ischemia. I have ordered a home sleep study to assess for degree of sleep apnea. Resident will be monitored for chest pain, palpitations, hypotensive/hypertensive episodes, dizziness, headache, or blurred vision. I have ordered a head CT to be performed to rule out insidious cause of the residents dizziness and nausea. The resident will be evaluated by neurologist. The nursing staff will arrange an appointment for pulmonary as well. The resident will start supplemental oxygen ATC [Around the Clock] at 2 L/min via nasal cannula. The nursing staff will monitor her for ongoing hypoxia, increased shortness of breath, PND [Paroxysmal Nocturnal Dyspnea], orthopnea, chest congestion, and wheezing. When asked if the pulmonologist appointment was rescheduled and if the sleep study was scheduled employee D stated that she could not find any evidence that the appointments were scheduled. On 5/15/24 during the end of day meeting the Administrator was made aware and no further information was provided.