STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Health and Rehabilitation Center	112 N Constitution Dr Yorktown, VA 23692

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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. Based on staff interview, clinical record review, and review of facility documents, the facility staff failed to ensure the care plan was revised for 1 of 8 residents reviewed for code status. The care plan did not accurately indicate the correct code status of the resident (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 12/9/24. The resident has never been discharged from the facility. The current diagnoses included discitis/ unspecified/lumbar region, type 2 diabetes mellitus with diabetic neuropathy, difficulty in walking, muscle weakness, morbid obesity due to excess calories, and major depressive disorder. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were moderately impaired. On 1/15/25 at 12:37 PM an interview was conducted with the Regional Nurse Consultant and the Director of Nursing (DON). The DON stated that Resident #1's code status is Full Code however the Care Plan reads that Resident #1 has an advance directive of Do Not Resuscitate (DNR). The DON further stated that there is a discrepancy between the Care Plan and the correct code status of Resident #1. On 1/16/25 at 12:07 PM an interview was conducted with the MDS (Minimum Data Set) Coordinator. The MDS Coordinator stated that she put the incorrect Care Plan in place. She also stated that Resident #1's code status was full code however the care plan indicated that Resident # 1 has an advance directive of Do Not Resuscitate (DNR). A care plan focus dated 12/19/24 read, Resident #1 has an advance directive of DNR. The goal read, the resident will have their advance directive wishes honored thru the review period. The interventions read, honor residents advance directive choices. On 1/16/25 at approximately 3:40 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. (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	The facility's Care Planning policy with an effective date of 11/1/19 read: Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and review of facility documents, the facility staff failed to follow the professional standards of quality regarding documentation for 1 of 8 residents (Resident # 1), in survey sample. The findings included: Resident #1 was originally admitted to the facility [DATE]. The resident has never been discharged from the facility. The current diagnoses included discitis/ unspecified/lumbar region, type 2 diabetes mellitus with diabetic neuropathy, difficulty in walking, muscle weakness, morbid obesity due to excess calories, and major depressive disorder. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were moderately impaired. On [DATE] at 12:21 PM an interview was conducted with the Regional Nurse Consultant and the Director of Nursing (DON). The Regional Nurse Consultant stated when Cardio-Pulmonary Resuscitation (CPR) is initiated, the Nurse will document using the Code Blue Progress Note and also document the information under progress notes in Point Click Care (PCC). The Regional Nurse Consultant further stated the Nurse did not document that CPR was initiated on Resident #1 on [DATE] using the Code Blue Progress Note or document any information in PCC. A review of Resident #1's medical records indicated that the Nurse did not document that CPR was initiated on Resident #1 on [DATE] using the Code Blue Progress Note or document any information in PCC. According to Mosby's: The following tips, recommendations, and best practices can ensure your documentation is as precise and useful as possible. 1. Be Accurate . 2. Avoid Late Entries . 3. Prioritize Legibility . 4. Use the Right Tools . 5. Follow Policy on Abbreviations . 6. Document Physician Consultations . 7. Chart the Symptom and the Treatment . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	https://www.google.com/search?q=Mosby%27s+nursing+documentation+cpr&rlz=1C1GCEJ_enUS1039US1039&oq=Mosby%27s+nursing+documentation+cpr&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQIRigATIHCAIQIRigATIHCAMQIRigATIHCAQQIRigATIHCAUQIRigAdIBCjI2ODk3ajBqMTWoAgiwAgE&sourceid=chrome&ie=UTF-8 On [DATE] at approximately 3:40 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. The facility's Cardio-Pulmonary Resuscitation (CPR) policy with an effective date of [DATE] read: A licensed nurse will document using the Code Blue Progress Note.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to provide supervision for a dependent resident who rolled off of the bed causing pain and discomfort for 1 of 8 residents (Resident #3), in the survey sample. The findings included: Resident #3 was originally admitted to the facility 09/12/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Unspecified Osteoarthritis and History of Falling. The 5-day admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/22/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #3 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with toileting hygiene, shower/bathe, lower body, requiring partial/moderate assistance with upper body, requiring set-up cleanup assistance with putting on taking off footwear, Upper and lower extremities are impaired on both sides. Mobility: Coded resident as requiring substantial/maximal assistance with rolling to the left and right. The care plan dated 12/17/24 read that Resident #3 is at risk for falls limited mobility, impaired cognition at times. The Goal for the resident is he will not have an injury related to a fall through the review period on 2/12/25. The interventions are: Two staff for bed mobility and incontinence care and to remind the resident to use their call light for assistance with Activity of Daily Living (ADLs). A review of an unwitnessed fall report dated 12/23/24 revealed that resident was found on the floor in his room laying on his right side. Resident said that he was on his side getting changed. Resident was assessed and neurological checks were started. No injuries observed at time of incident. Family member and physician were notified on 12/23/24. A review of the Radiology report dated 12/23/24 revealed that a chest x-ray,of the Right elbow and Right knee reveal no acute fractures. A review of the neurological checks initiated on 12/23/24 at 6:50 AM., show they were completed from start to finish. A review of the Post Fall risk scoring tool was completed on 12/23/24. A review of progress notes dated 12/23/24 at 5:23 AM., read that Resident #3 had a fall from his bed while receiving morning care when he rolled off the side of the bed. The Resident fell on his right side and complained of chest and pain to his right elbow. The resident also hit his chin. No joint and limb abnormalities, neuro checks started. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at approximately12:35 PM., an interview was conducted with Resident #3 during the initial tour. Resident #3 said that he rolled off his bed while receiving incontinent care from a Certified Nursing Assistant (CNA) about a month ago hitting his chin, knees, right hand and right elbow. Resident #3 also said that the CNA left him on his side, he fell with the bed in high position. The resident also said that he was in pain, and that x-rays were taken. On 1/16/25 an interview was conducted with CNA (C) at approximately 12:10 PM., CNA, C said that she had heard that the resident fell out of his bed while receiving incontinent care but was not present due to working a different shift. On 1/16/25 at approximately 12:30 PM., an interview was conducted with Licensed Practical Nurse (LPN) C. LPN C said that while the CNA was changing the resident, she (LPN C) was standing outside of the resident's room and saw the CNA at the sink when the resident fell, landing on his right side. LPN C also mentioned that Resident #3 complained of his shoulder hurting, x-rays were ordered and taken of the right side of the resident's body. LPN C then mentioned that the CNA had the bed set to her height and that normally, the staff would tag team the with the CNAs but she was agency staff and thought she could handle him by himself. LPN stated that they never provide ADL care to the resident by themselves. On 1/16/25 at approximately 1:50 PM., an interview was conducted with The Director of Nursing (DON) concerning Resident #3's fall. The DON said that the CNA was agency staff that refused to write a statement concerning the resident falling out of the bed. The DON also said that the agency CNA said that as she was performing ADL care, the resident jerked and fell out of the bed. On 01/16/25 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on information obtained during the as worked nursing schedule nursing staff, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week which could potentially affect all residents. The facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The findings included: A review of the as worked schedules dated 12/23/24, 1/04/25 and 1/11/25 reveal that the facility staff was unable to verify 8 consecutive hours a day of RN coverage for at least 3 days. The above dates were verified by the Scheduling Coordinator on 1/16/25 at approximately 1:40 PM. A final interview was conducted on 1/16/25 at approximately 1:00 PM., with the Administrator. The administrator said that there should be RN, 8 hours coverage.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure the posting of nurse staffing information on the nursing unit. The findings included: During the initial tour of the facility on 1/14/2025 at 11:00 a.m., there was no observation of nurse staffing data posted. The facility only had one nursing unit. There was no posting in the lobby area nor in the main hall of the facility. On 1/14/2025 at 4:15 p.m., there was no observation of nurse staffing data posted on the unit. On 1/15/2025 at 9:45 a.m., there was no observation of nurse staffing data posted on the unit. On 1/15/2025 at 3:55 p.m., there was no observation of nurse staffing data posted on the unit. On 1/15/2025 at 3:58 p.m., an interview was conducted with a visitor who stated he visited the facility daily to spend time with his wife who resided there. When asked how he knew how many staff members were working when he visited, he stated he didn't ever know a number but would look for staff when he needed them. The visitor stated he had never seen the staffing posted. On 1/16/2025 at 9:30 a.m., there was no observation of nurse staffing data posted on the unit. On 1/16/2025 at 1:40 p.m. interview with the Scheduling coordinator who stated she had been employed for over a year and did not ever post the nurse staffing data. She stated she kept that information in her office at her desk. The Scheduling Coordinator stated she did not know it needed to be posted on the unit. She also stated that since she did not work all shifts, she thought the unit managers or charge nurses could post the information when she was not working. The Scheduling Coordinator provided copies of the as worked schedules for Surveyor C upon request. The information on those schedules was not posted on the unit. On 1/16/2025 at 2:30 p.m., an interview was conducted with the Regional Nurse Consultant who stated the nurse staffing should be posted daily at the beginning of each shift. The Regional Nurse Consultant walked around the nursing unit along with the Surveyor B and stated she did not see any posting of nurse staffing data. During the end of day debriefing on 1/16/2025, the Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings that there was no posting of the nurse staff information on the unit nor anywhere in the facility during the 3 days of survey. No further information was provided.