STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to review and revise care plan for 1 Resident in survey sample of 9 Residents. The findings included: For Resident #3 the facility staff failed to review and revise care plan after 9 incidents of elopement or attempted elopement between 5/23/24 and 8/23/24. A review of the clinical record revealed the following excerpts from the care plan: FOCUS: The resident is at risk for elopement related to exit seeking. GOAL: Resident will be monitored for exit attempts, constant staff observations for attempts Date Initiated: 02/01/2024 Revision on: 05/08/2024 The resident will not elope thru review period Date Initiated: 11/14/2023 Revision on: 05/14/2024 INTERVENTION: check function weekly Date Initiated: 11/14/2023, check placement every shift Date Initiated: 11/14/2023 Code orange when occur Date Initiated: 04/29/2024, elopement risk assessment as needed Date Initiated: 05/14/2024, Redirect from exit Date Initiated: 11/14/2023. On 9/5/24 at approximately 3 p.m. an interview was conducted with LPN B who stated that care plans should be updated when there are any new changes in Resident care or condition. When asked if this included if a Resident elopes or wanders away from the building, and she stated that it should be included in the care plan and the care plan should be updated to add any new interventions to prevent it from happening again. On 9/5/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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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(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 - Immediate jeopardy to resident health or safety 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** 40026 Based on interviews, clinical record review, and facility documentation, the facility staff failed to ensure the Residents were free of accident hazards and provided adequate supervision for two (2) Residents (#3 and #4) in a survey sample of nine (9) Residents. This resulted in immediate jeopardy for Resident #3 and potential for harm for Resident #4. The findings included: 1. For Resident # 3, the facility staff failed to provide supervision while smoking outside of the building, allowing Resident #3 to leave the facility grounds unsupervised. Resident #3 was admitted to the facility on [DATE] with diagnoses that included but were not limited to generalized anxiety disorder, depression, unspecified intellectual disability, alcohol dependence with withdrawal, alcohol-induced persistent dementia, other symptoms and signs involving cognitive awareness, and respiratory conditions due to smoke inhalation. Resident #3's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/5/24, assessed by the facility Social Worker, scored Resident as a 5/15, indicating severe impairment in cognitive skills. On 9/4/24, a review of the smoking policy revealed the following information: Patients smoking in the designated smoking grounds area are to be supervised as deemed appropriate through their individual Safe Smoking Assessment. The Safe Smoking Assessment screening was reviewed on 5/27/24 and 8/27/24. Resident #3 received scores of 2 and 0. According to the key, a score of 0-4 is considered safe to smoke unsupervised. [Please note that the smoking assessment screens explicitly for the ability to light and handle smoking materials physically.] A review of the elopement assessments revealed that on 2/14/24, Resident #3 scored a 10; on 5/14/24, again, a 10; and on 8/14/24, 11 was scored, all three indicating a high risk of elopement. On 9/4/24 at approximately 1:00 p.m., Resident #3 was noted to be outside the building smoking with other residents, and she returned to the building after she finished smoking. On 9/4/24, at approximately 2:00 p.m., Resident #3 was interviewed. She said she never left the building unsupervised or went to the store. She stated that the staff always opened the door for her to smoke outside. She denied ever wandering off or going to buy beer at a store. At this point, Resident #3 ended the interview by walking away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/4/24, at approximately 11:00 a.m., the receptionist was observed bypassing the wander guard alarm for another resident to go outside to smoke. When asked what the sound was, she stated it was the wander guard alarm. When asked if she bypassed it by putting in the code, she said she did. When asked why, she stated that the Resident was a smoker and allowed to go and smoke. A review of the clinical record on 9/4/24 revealed that Resident #3 had eloped from the facility grounds on several occasions since May 23, 2024. The following excerpts are from the clinical record regarding Resident #3's elopement: 5/23/24 1:39 p.m. -Writer contacted by nurse that resident was seen near road at entrance of facility when nurse tried to redirect resident walked back towards back of facility. Writer traveled to back of building where resident was located. Resident stated that she was just walking around. Writer explained to resident that it is not safe to walk around outside the facility without a staff escort. Resident stated she was trying to exercise. RP was made aware. 6/12/24 2:03 p.m. - Code orange called at 1250 pm as patient was seen walking off the premises. Patient was able to be redirected inside the building when asked why she left patient stated she no longer wanted to live here, she is bored and has nothing to do. 6/14/24 6:09 p.m. - She eventually put out the cigarette but continuously kept trying to walk off the facility premises. Twice she was redirected back while she agitated and using profane words at staff. She refused all her medications. RP notified. 7/18/24 10:18 a.m. - Left facility unsupervised to go to the store. Resident found at the store purchasing Alcohol. 7/28/24 8:39 p.m. - [Resident name redacted] was seen by staff at approximately 6:00 pm. A fell ow resident who had walked to the store stated she was at the store with him but when he turned around, she was gone. The supervisor called a code orange, notified the police, called the RP, notified the DON and the administrator. Within 10 minutes she was located by her RP. Police were notified that she was found safe and was with a relative. The administrator and DON were also notified. The RP stated she would keep her for an hour or so to calm her down and then return her to the facility. Upon her return resident was still noted to be agitated and still continued to leave the premises. She attempted to hit staff and was physically aggressive with her aunt. Resident will be seen by psych services this week. MD notified. Skin assessment completed no injuries. 8/1/24 3:51 p.m. - Spoke with [Responsible party name redacted] to make her aware that [Resident #3 name redacted] left the property and was at the [NAME] store and the cashier explained to staff that [Resident name redacted] is banned from their property. 8/2/24 7:30 p.m. - Resident has been leaving facility property since 2130 [sic]. Care staff was able to redirect resident back into facility. Resident then later insisted on going to the nearby store for something she wanted, and she wasn't coming back into the facility until she was ready. Resident was assisted back to facility by another staff member where she remains in her room on the phone at the time of this writing. 8/2/24 8:36 p.m. - Type of Behavior: Elopement (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Non-pharmacological Intervention: Talked and walked around the parking lot w/ her for a few minutes until she was ready to go back inside. 8/2/24 9:11 p.m. - Writer noticed resident walking by with alcohol in a bag going to her room. Writer attempted to ask resident to see what she had but she refused. 8/2/24 9:35 p.m. - Resident has left facility grounds unattended. 8/2/24 9:52 p.m. - Resident returned back to facility at 7:45 pm accompanied by writer 8/4/24 5:27 p.m. - Resident was reported to have left the facility unattended. Writer went outside in search of resident and CNA followed in her car. Resident was found at the [name of store redacted] store and she stated she was getting a drink but had no money. When advised to get in the car so she could return to the facility, she refused, crossed the street and kept walking towards the direction of the highway. Another nurse [nurse's name redacted] was informed at the facility to contact resident's RP while writer kept following Resident down the street, advising her to return. Resident eventually turned around, and her RP picked her up mid-way back to the facility. 8/23/24 6:56 p.m. - Resident was noticed to have left the facility around 1730 [5:30 p.m.]. A code orange was called but resident could not be found in or around the building. She could not be found at the [NAME] gas station. RP and DON were notified. Resident was found coming back from the direction leading to the 7-11. She was encouraged by writer and RP who had driven to the facility to assist in finding resident to return back to the facility. Resident walked back to building with writer. Immediate Jeopardy (IJ) was identified and verified after consultation with the state Licensure and Certification supervisory Staff on 9/5/24 at 12:47 p.m. The facility Administrator and Director of Nursing (DON) were made aware of IJ on 9/5/24 at 12:50 p.m. On 9/6/24 at 2 p.m., the facility submitted approved IJ Removal Plan: a) Immediate Supervision: As of 9/5/24 at 1:35 p.m., resident #3 is now under 1:1 supervision 24/7 to prevent elopement. As of 9/5/24, a dedicated staff member has been assigned to always monitor during smoke breaks. b) Wander Guard System: On 9/5/2024 at 1:35 p.m., the Resident #3 wander guard bracelet was assessed and functioning well. On 9/5/2024, the maintenance team re-evaluated and recalibrated the facility's wander guard system to ensure it functions correctly. All in-place wander guards have been checked and are working successfully. As of 9/5/2024, the facility has initiated training for all its staff on the importance of not passing the wander guard system and the potential consequences of doing so. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c) Environmental Modifications: The front door will remain locked, and staff will continue to monitor exit doors, especially during high-risk periods when Resident #3 is likely to attempt to leave (e.g., smoking times). d) Smoking: As of 9/5/2024, Resident #3 will continue not to be allowed to smoke unsupervised. A designated smoking area has been established within a secure part of the facility, and staff will escort Resident #3 to and from this area. e) Staff Education and Training: On 9/5/2024, all staff will undergo immediate re-education on elopement risks, supervision requirements, and the specific needs of residents with cognitive impairments. Training sessions have been initiated to reinforce the importance of adhering to safety protocols and using the wander guard system. The plan is for all staff to report for oncoming shifts; they will not work until all re-education is complete. f) Resident Care Plan Review: On 9/5/2024 at 1:35 p.m., Resident #3's care plan was reviewed and updated to include specific interventions to prevent elopement. The care plan now includes detailed instructions for staff on supervising Resident#3 during all activities, including smoke breaks. The facility alleges compliance as of 9/6/24 at 1:00 p.m. Long Term Actions: i.) Ongoing Monitoring Regular audits will ensure compliance with the updated supervision protocols. While the patient remains in the facility, Resident #3's care plan will be reviewed monthly to assess the effectiveness of the interventions and make necessary adjustments. ii.) Family and Resident Involvement: As of 9/5/2024 at 1:50 p.m., Resident #3 and her family have been informed of the situation and steps to ensure her safety. Regular meetings will be held with the family to discuss concerns and provide updates on Resident #3's status. iii.) Policy Review and update: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As of 9/5/2024, the facility's elopement policy has been reviewed and updated to reflect the new measures. All staff have received a copy of the updated policy and must acknowledge their understanding and commitment to following it. iv.) Quality Assurance As of 9/5/2024, a QA committee has been established to oversee the implementation of the abatement plan and ensure ongoing compliance. The QA committee will meet bi-weekly to review incident reports, monitor the effectiveness of interventions, and recommend further improvements as needed. The Survey Team verified that the following components of the Removal plan had been fully implemented on 9/6/24: The survey team reviewed the education provided and interviewed the staff on duty to ensure they had been trained and understood the content. The staff were questioned about Resident #3's supervision during smoke breaks and when she was out of the facility. The survey team reviewed the policy to ensure the updates included supervision while smoking in the designated smoke area. A review of the clinical record revealed that the facility staff updated the care plan to include, due to the resident's cognitive status, the need for supervision at all times while smoking. The facility staff documented contacting the Resident's Responsible Party and working together to find a facility with a more appropriate setting to provide enhanced security for the Resident. On 9/5/24, at approximately 2:00 p.m. (after the facility was informed of the immediate jeopardy), staff members were observed walking in the hallway with Resident #3. On 9/6/24, at approximately 9:00 a.m., Resident #3 was observed to have one-to-one (1:1) supervision outside in a sanctioned area during a smoke break. On 9/6/24 at 10:30 AM, the resident was also observed during a structured activity with 1:1 supervision. On 9/6/24 at 3:00 p.m., the survey team informed the Administrator that the IJ was removed based on validation of their removal plan and the scope and severity of the deficiency was lowered to a level 2, isolated. 2. For Resident #4, the facility staff failed to ensure the maintenance person had removed all tools from the roof after repairs, causing a hammer to fall on Resident #4's head, resulting in an evaluation in the emergency room . Resident #4 was admitted to the facility on [DATE]. Diagnoses for Resident #4 included but were not limited to pulmonary embolism, type 2 diabetes, acute kidney failure, seizure, substance abuse, hypertension, pancreatic cancer, and emphysema. Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/16/24 coded Resident #4 with a BIMS (Brief Interview of Mental Status) score of 13/15 indicating no cognitive impairment. Minimum Data Set Coded Resident #4 as #1- supervision from staff for Activities of Daily Living care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/5/24, a review of the clinical record revealed the following notes: 8/24/24 3:08 p.m.- On the day of Aug. 24, 2024, resident was involved in incident where nursing staff felt an assessment from E.R. should be required. [Resident #4 name redacted] at one point began to refuse to go to ER to be evaluated because he was afraid of losing room placement. We assured him that admission would follow up with him and he would be notified before any changes would occur. Resident later after strong encouragement from staff decided to go to E.R. to be evaluated. 8/25/24 1:30 p.m. -LATE ENTRY -Situation: Date and time the fall occurred: 08/24/2024 1:21 PM Background: Circumstances of the fall: Resident's cane was placed on roof of building, resident attempted to retrieve his cane from roof, and was hit in the head by object off roof. Assessment (RN)/Appearance (LPN): Current status of the resident's injuries or reports of pain from the fall: Resident has area to top of scalp, dry and intact Resident c/o pain 5/10 Recommendation: Interventions currently in place to prevent additional falls: Resident educated to ask for assistance resident's response to new interventions: Resident compliant. On 9/5/24, a clinical record review revealed that Resident #4 went to theER on [DATE] and was evaluated and released. There were no new orders; CT imaging of the head and neck was done to confirm no acute fractures or serious injury from the incident. The following excerpt was from the physician's notes. 9/2/24 1:00 p.m. -Patient discussed that he has been recovering and attempting to feel better physically. He reports a hammer fell off the roof the building when he attempted to retrieve his cane from the roof. Patient said it was hanging off the side of the building and a hammer fell and hit him on the head. Patient then reports he did not recall a lot of things. Patient said he was medically cleared at a hospital and has been following doctor's order. 9/5/24 at approximately 12:00 p.m. an interview was conducted with Resident #4 who stated he is feeling much better and still did not know how his cane came to be hanging off the side of the roof. He stated that he reached for it and then it must have knocked the hammer off when it came down on his head. He stated that he went to the emergency room , and they did some tests and x-rays and sent him back to the facility. When asked if he felt fearful or unsafe at the facility, he stated that he did not. He stated it was a 'Crazy accident.' On 9/5/24 at approximately 3:00 p.m. an interview was conducted with the Administrator who stated that the incident did happen an investigation was done, and the maintenance person was educated on ensuring tools were not left where they could injure residents. On 9/5/24 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on observations of the facility, they failed to provide a sanitary environment for residents, staff and the public. The findings included: The facility staff failed to provide a sanitary environment for residents, staff and the public. During the initial tour of the facility on 9/3/2024 at 8:30 p.m., three grills were observed outside the door of the wing (unit) facing the left side of the parking lot. At 9:15 p.m., two surveyors looked near the area around the grills. Several large cockroaches were observed scurrying on the sidewalk and in the bushes near the door. The cockroaches were approximately 3 inches in length. When the lids to each grill were lifted, there were soiled aluminum foil sheets observed on each of the grill grates with noted food debris. The grills remained in the same location until 9/5/2024 around 4:00 p.m. in the afternoon, after the administrator was informed about the findings. On 09/04/2024, at approximately 10:00 AM, during a morning meeting, the surveyors were approached by a resident's family member. She stated she was concerned with the facility and rodents. Stated that her mom was admitted to room [ROOM NUMBER] on 09/03/ 24 in the afternoon. She went on to say that after getting her mom (Resident #6) settled in her room for the night, she left the facility at approximately 7:00 p.m. The family member states that her mom, (Resident #6), called her at 11:00 p.m. and informed that she had mice in her room. Resident # 6 went on the say that there were mice running from the bathroom to the hole seen under the sink in her room. Also stating that she saw 4 mice at one time. The family member provided pictures the mice. On 09/04/2024, at approximately 12:45 p.m., during an afternoon tour room [ROOM NUMBER] on the South Unit was observed to have a small hole under the sink and a medium size hole in the bathroom. There was 1 bated paper trap, and 2 Sticky traps, which captures everything crawling across it, and the insect or rodent would be trapped in the glue covered top. On 09/05/2024, an interview was conducted with Resident #6. The Resident stated that she was just laying in bed and noticed out the corner of her eye a mouse run across the floor. She states that she saw four at one point and what appeared to be a potato chip bag. Resident #6 also provided pictures that she captured from her bed of mice and what appeared to be a large water bug. On 09/05/2024 an interview was conducted with the Maintenance Manager who states they have had issues with mice and some insects. He went on to say they have a Pest Control Contract, and that the Contractor comes once a week, on Thursdays, and treats all common areas and areas of sightings. A review of the pest control log revealed the Control Company provided service weekly to common areas, and most recently spot and room treatments to room [ROOM NUMBER], 33, 39, 34, 43, 59, 57, and 47 on 08/26/24 with Glue Boards. On 9-04-24 the Administrator and the Director of Nursing were made aware of the findings. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on observation, interview, and facility documentation, the facility staff failed to maintain an effective pest control program. The findings included: The facility staff failed to maintain an effective pest control program so that the facility is free of pests, to include mice, involving 2 of 2 units in the facility. During the initial tour of the facility on 9/3/2024 at 8:30 p.m., three grills were observed outside the door of the wing (unit) facing the left side of the parking lot. At 9:15 p.m., two surveyors looked near the area around the grills. Several large cockroaches were observed scurrying on the sidewalk and in the bushes near the door. The cockroaches were approximately 3 inches in length. When the lids to each grill were lifted, there were soiled aluminum foil sheets observed on each of the grill grates with noted food debris. The grills remained in the same location until 9/5/2024 around 4:00 p.m. in the afternoon, after the administrator was informed about the findings. On 09/04/2024, at approximately 10:00 AM, during a morning meeting, the surveyors were approached by a resident's family member. She stated she was concerned with the facility and rodents. Stated that her mom was admitted to room [ROOM NUMBER] on 09/03/ 24 in the afternoon. She went on to say that after getting her mom (Resident #6) settled in her room for the night, she left the facility at approximately 7:00 p.m. The family member states that her mom, (Resident #6), called her at 11:00 p.m. and informed that she had mice in her room. Resident # 6 went on the say that there were mice running from the bathroom to the hole seen under the sink in her room. Also stating that she saw 4 mice at one time. The family member provided pictures the mice. On 09/04/2024, at approximately 12:45 p.m., during an afternoon tour room [ROOM NUMBER] on the South Unit was observed to have a small hole under the sink and a medium size hole in the bathroom. There was 1 bated paper trap, and 2 Sticky traps, which captures everything crawling across it, and the insect or rodent would be trapped in the glue covered top. On 09/05/2024 an interview was conducted with Resident #6. The Resident stated that she was just laying in bed and noticed out the corner of her eye a mouse run across the floor. She states that she saw four at one point and what appeared to be a potato chip bag. Resident #6 also provided pictures that she captured from her bed of mice and what appeared to be a large water bug. On 09/05/2024 an interview was conducted with the Maintenance Manager who states they have had issues with mice and some insects. He went on to say they have a Pest Control Contract, and that the Contractor comes once a week, on Thursdays, and treats all common areas and areas of sightings. A review of the pest control log revealed the Control Company provided service weekly to common areas, and most recently spot and room treatments to room [ROOM NUMBER], 33, 39, 34, 43, 59, 57, and 47 on 08/26/24 with Glue Boards. On 9-04-24 the Administrator and the Director of Nursing were made aware of the findings. (continued on next page)

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Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided.