STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49917 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to ensure one resident was safe from falling during ADL Care, which constituted harm for 1 of 8 residents (Resident #4), in the survey sample. The findings included: Resident #4 was originally admitted to the facility 2/12/22. The resident was last discharged from the facility to a local hospital after a fall and returned 6/26/24. The resident's diagnoses included left hip fracture, distal right femur periprosthetic displaced comminuted fracture, anemia, muscle weakness, hypertension, and depression. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/2/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were intact. A fall risk assessment was conducted on 4/18/24. Resident #4 was categorized as requiring assistance or supervision for mobility, transfer, or ambulation. A review section GG (Functional Abilities and Goals) dated 5/4/24 of Resident #4's Minimum Data Set (MDS) coded the resident as dependent for rolling left to right, dependent for sit to lying, and dependent for lying to sitting on side of bed. A synopsis of an event dated 6/22/24 revealed that Certified Nursing Assistant (CNA) #1 was providing incontinent care to Resident #4 and needed clean linen. Prior to leaving the resident room to retrieve clean linen, CNA #1 positioned Resident #4 on her left side and told the resident to roll back to the middle of the bed if needed. While CNA #1 was out of the room, Resident #4 was attempting to roll back to the middle of the bed and fell out of the bed onto the floor resulting in a left hip fracture and distal right femur periprosthetic displaced comminuted fracture. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/1/24 at 1:30 PM an interview was conducted with Resident #4. Resident #4 stated that CNA #1 was providing incontinent care and needed clean linen. Resident #4 further stated that CNA #1 positioned her on her left side and told her that she was leaving the room and to roll to the middle of the bed if she needed too. Resident #4 voiced that she started to fall and was yelling for help. Resident #4 further voiced that she could no longer stay on the bed, fell off the bed and hit the floor. Resident #4 also stated that CNA #1 was out of the room between 3 to 4 minutes before she fell out of the bed. A review of Resident #4's nurses note dated 6/22/24 at 2:58 AM read that the resident was laying on her left side when CNA #1 finished incontinent care and exited room to get fresh linen. The nurses note further read that CNA #1 asked the resident to roll back to the middle of the bed, resident was attempting to roll back to the middle of the bed but instead pulled herself closer to the edge of the bed, her legs fell off the side of the bed which caused the rest of her body to fall as well. On 8/1/24 at 11:15 AM an interview was conducted with the Director of Nursing (DON). The DON stated that that Resident #4 is dependent regarding rolling left to right in the bed. The DON also stated that before the fall that occurred on 6/22/24, Resident #4 was dependent for mobility. The DON also voiced that the fall that occurred on 6/22/24 was due to CNA #1 leaving the room to get supplies while performing incontinent care. The DON further voiced that CNA #1 was an Agency CNA and was asked not to return to the facility or any of the (company name of associated nursing facilities) due to the unsafe practice that occurred. On 8/1/24 at 5:00 PM an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated that CNA #1 left the resident room looking for clean linen and also left Resident #4 laying on her left side. LPN #1 also stated that CNA #1 performed an unsafe practice when she left the resident room, and this contributed to Resident #4 falling out of the bed. A review of the Discharge Summary from a local hospital dated 6/26/24 read Resident #4's discharge diagnosis as a left hip fracture and distal right femur periprosthetic displaced comminuted fracture. All residents who had experienced falls with major injuries since 3/18/24 were reviewed during the survey, no additional deficient practice was identified. The facility developed a five-point plan secondary to Resident #4's fall with a left hip fracture and distal right femur periprosthetic displaced comminuted fracture. 1. 100 percent education to all clinical staff regarding falls protocol including ensuring residents are left in a safe position prior to leaving the resident unattended. 2. The facility completed a 100 percent review of all residents requiring assistance with activities of daily living care in the bed and the need for additional interventions. 3. The Director of Nursing or designee to complete weekly audits that include 5 staff members audited weekly for 12 weeks for proper positioning while providing activities of daily living care. 4. The Director of Nursing or designee to complete weekly audits that include 5 residents audited weekly for 12 weeks for proper positioning while providing activities of daily living care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5. Corrective action was completed on 7/8/24. All residents who had experienced falls with major injuries since 3/18/24 were reviewed during the survey, no additional deficient practice was identified. On 8/1/24 at approximately 6:40 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, and Regional Director of Clinical Services. 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. It was determined that the facility implemented its Corrective Action Plan and there was sufficient evidence through the sampled resident observations and interviews that residents were left in a safe position prior to leaving the resident unattended per their assessments and care plan. It was determined that the facility corrected the noncompliance and was in substantial compliance as of their Allegation of Compliance (AOC) date, 7/8/24 and at the time of the current survey for the regulatory requirement, F-689.