

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Chelsea Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 Dogtown Road Goochland, VA 23063	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>32642</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the provider of a resident's change in condition in a timely manner for one of seven residents in the survey sample, Resident #1.</p> <p>The findings include:</p> <p>For Resident #1 (R1), the facility staff failed to notify the physician in a timely manner of neurological status changes after a fall.</p> <p>A review of R1's clinical record revealed the following progress notes:</p> <p>3/31/24 at 7:50 p.m. Falls/Trauma .Altered level of consciousness .Patient initial evaluation post fall stable VS (vital signs) WNL (within normal limits). Patient c/o (complained of) pain to left side of head in area of hematoma. Neuro (neurological check) #4 pupils unequal, non-reactive. Patient not following commands appropriately, c/o being nauseated. Recommend sending to ER (emergency room).</p> <p>3/31/24 at 10:15 p.m. Made aware by CNA (certified nursing assistant) at approximately 1950 (7:50 p.m.) that resident was found on the floor. Went to assess resident. Resident was observed laying (sic) on the floor on her left side. Resident noted to have large hematoma to the left forehead. Patient assessed. Vital signs and neuro checks WNL. Patient transferred back to bed by CNA and nurse. Neuro checks initiated. C/o pain only to forehead at location of hematoma. Patient stated that she was taking the 'boys' back to the house. Patient is unsure of where she is and can only state her name and birthday at this time. Of note she does have dementia .At approximately 2020 (8:20 p.m.) while completing the 4th neuro check, patient noted to be moaning and in pain. At this neuro check pupils were not equal. Left was larger than right. Neither pupil reacted to light. At this time .the patient was also noted to be rather drowsy, having a difficult time following directions and complaining of being nauseated. 911 was called and report given to EMS (emergency medical services). Patient was taken to [name of local hospital].</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the neuro check record for R1 dated 3/31/24 revealed entries for 7:35 p.m. and 7:50 p.m. indicating R1's pupils were equally reactive, but were sluggish reacting to light. The entry for 8:05 p.m. did not have documentation regarding whether the pupillary reactions were brisk or sluggish. The entries for 8:20 p.m. and 8:35 p.m. indicated R1's level of consciousness had declined from alert to drowsy, and that her pupils were not reactive at all to light. These entries also indicated the resident was no longer able to follow verbal commands.</p> <p>A review of R1's provider's orders revealed she was receiving Eliquis (1) and Aspirin at the time of her fall, both of these medications making her blood thinner and clotting more difficult.</p> <p>On 12/9/24 at 2:58 p.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. She stated neuro checks should include a resident's vital signs, pupil reactions to light, and level of consciousness. She stated the nurse should assess whether the resident's pupils react briskly or sluggishly or not reactive at all. When asked the next step to be taken if a nurse finds sluggish pupils, she stated: The would call the doctor or the NP (nurse practitioner) right away. She stated sluggish pupils are not typically within normal limits for any resident. ASM #2 was asked to find evidence the nurse who assessed R1 neurologically after the resident's fall (this nurse was not available for interview at the time of the survey) took timely action when the resident's pupils were both sluggish immediately after the fall.</p> <p>On 12/9/24 at 3:36 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated neuro checks include pupils, hand grasps, and mobility per a resident's baseline. She stated if a resident's pupils are sluggish on assessment, she would definitely call the provider, either the attending physician or NP, immediately. After reviewing R1's records, LPN #1 stated she would have called the doctor much sooner.</p> <p>On 12/9/24 at 4:06 p.m., ASM #1, the executive director, ASM #2, and ASM #3, the regional nurse consultant, were notified of these concerns.</p> <p>A review of the facility policy, Neurological Assessment (Routine), revealed, in part: Routine neurological assessment is conducted to evaluate the resident for small changes that may be indicative of neurological injury .Test pupillary reaction to light .Notify the physician of any change in a resident's neurological status.</p> <p>A review of the policy, Change in a Resident's Condition or Status, revealed, in part: Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status .The nurse will notify the resident's attending physician or physician on call when there has been a .significant change in the resident's physical .condition.</p> <p>No additional information was provided prior to exit.</p> <p>Reference (continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(1) Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.html.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>32642</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to develop an accurate baseline care plan for one of seven residents in the survey sample, Resident #1.</p> <p>The findings include:</p> <p>For Resident #1 (R1), the facility staff failed to include the risks of taking anticoagulants on the baseline care plan.</p> <p>A review of R1's clinical record revealed the following provider's orders on admission:</p> <p>3/28/24 Aspirin Oral Tablet Chewable 81 MG (milligrams) (Aspirin) Give 1 tablet by mouth one time a day.</p> <p>3/28/24 Apixaban (Eliquis) (1) 2.5 mg Give 1 tablet by mouth two times a day.</p> <p>On 12/9/24 at 2:39 p.m., RN (registered nurse) #1 was interviewed. She stated she believed the admission nursing assessment is the beginning of the resident's baseline care plan, but other information to complete the baseline care plan should probably be included. When asked if a resident's taking both Aspirin and Eliquis as blood thinners should be on a resident's baseline care plan, she stated that it should. She stated these two medications increase a resident's potential for bleeding.</p> <p>On 12/9/24 at 3:36 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the assessments that nurses perform when a resident is admitted to the facility contribute to the baseline care plan. She stated the baseline care plan contains the basic information needed to take care of a resident day to day. She stated anticoagulant use should be included on the baseline care plan.</p> <p>On 12/9/24 at 4:06 p.m., ASM #1, the executive director, ASM #2, and ASM #3, the regional nurse consultant, were notified of these concerns.</p> <p>A review of the policy, Care Plans - Baseline, revealed, in part: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following .physician orders.</p> <p>No additional information was provided prior to exit.</p> <p>Reference</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>32642</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to respond to a resident's change in condition in a timely manner for one of seven residents in the survey sample, Resident #1.</p> <p>The findings include:</p> <p>For Resident #1 (R1), the facility staff failed to respond to her neurological status changes after a fall.</p> <p>A review of R1's clinical record revealed the following progress notes:</p> <p>3/31/24 at 7:50 p.m. Falls/Trauma .Altered level of consciousness .Patient initial evaluation post fall stable VS (vital signs) WNL (within normal limits). Patient c/o (complained of) pain to left side of head in area of hematoma. Neuro (neurological check) #4 pupils unequal, non-reactive. Patient not following commands appropriately, c/o being nauseated. Recommend sending to ER (emergency room).</p> <p>3/31/24 at 10:15 p.m. Made aware by CNA (certified nursing assistant) at approximately 1950 (7:50 p.m.) that resident was found on the floor. Went to assess resident. Resident was observed laying (sic) on the floor on her left side. Resident noted to have large hematoma to the left forehead. Patient assessed. Vital signs and neuro checks WNL. Patient transferred back to bed by CNA and nurse. Neuro checks initiated. C/o pain only to forehead at location of hematoma. Patient stated that she was taking the 'boys' back to the house. Patient is unsure of where she is and can only state her name and birthday at this time. Of note she does have dementia .At approximately 2020 (8:20 p.m.) while completing the 4th neuro check, patient noted to be moaning and in pain. At this neuro check pupils were not equal. Left was larger than right. Neither pupil reacted to light. At this time .the patient was also noted to be rather drowsy, having a difficult time following directions and complaining of being nauseated. 911 was called and report given to EMS (emergency medical services). Patient was taken to [name of local hospital].</p> <p>A review of the neuro check record for R1 dated 3/31/24 revealed entries for 7:35 p.m. and 7:50 p.m. indicating R1's pupils were equally reactive, but were sluggish reacting to light. The entry for 8:05 p.m. did not have documentation regarding whether the pupillary reactions were brisk or sluggish. The entries for 8:20 p.m. and 8:35 p.m. indicated R1's level of consciousness had declined from alert to drowsy, and that her pupils were not reactive at all to light. These entries also indicated the resident was no longer able to follow verbal commands.</p> <p>A review of R1's provider's orders revealed she was receiving Eliquis (1) and Aspirin at the time of her fall, both of these medications making her blood thinner and clotting more difficult.</p> <p>(continued on next page)</p>		

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