STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaufont Health and Rehabilitation Center	200 Hioaks Road Richmond, VA 23225

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide a comprehensive care plan for respiratory care and services to maintain the highest practicable wellbeing for one resident, (Resident #1) in a survey sample of 2 residents. The findings included: For Resident #1, the facility staff failed to assess and monitor the Resident's respiratory status and intervene with appropriate measures prior to the death of the Resident who was suffering labored breathing & respiratory difficulty. No other tracheostomy Residents were residing in the facility at the time of survey so could not be added to the sample. Resident #1 was a discharged Resident so a closed record review was conducted. The Resident was originally admitted to the facility from the hospital on [DATE] with diagnoses including; Acute Osteomyelitis to the right shoulder (primary diagnosis) and a history of Laryngeal cancer with total laryngectomy surgical removal in 1987, anemia, diabetes, hypertension, dementia without behavior disorder, and hospice was ordered on [DATE] with comfort measures and a Do not resuscitate (DNR) order. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of [DATE]. Resident #1 was coded with mild cognitive impairment. Resident #1 required substantial assistance to complete dependence on staff members for activities of daily living. On [DATE] Resident #1's former room mate (Resident #2) was interviewed and found to be alert, and oriented to person, place, time, and situation. The Resident described the friendship that had occurred between herself, Resident #1, and the family of Resident #1 during their time as room mates. She stated that Resident #1's husband brought food to her every day. Resident #2 was asked if suctioning and oxygen were in the room that they shared, and she stated no, she never used oxygen, and she had never seen suctioning completed for Resident #2, and that no machine was kept in the room. She stated that Resident #1's husband would clean her neck stoma everyday, and further stated that the Resident would at times have a partially clogged stoma which gurgled and staff would clean it, but she never saw or heard suctioning. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] LPN A, and LPN B (Licensed Practical Nurses) were interviewed at the nursing station beginning approximately at 11:45 AM. Both nurses stated they had received training in the care of patients with tracheostomys and stomas, suctioning, administration of oxygen by way of nasal cannulas, masks, emergency CPR, ambu bags, and tracheostomy stoma masks for oxygen delivery, and were able to verbalize the situational uses and applications. Those interviews continue below; LPN A stated that she had cared for Resident #1, and Resident #2 and stated that Resident #1 had been alert and interactive and at times could even be combative when she didn't want anyone bothering her. LPN A went on to say both Residents were good cognitively. LPN A was asked if she was working on the day that Resident #1 expired, and she stated she was not caring for Resident #1 that day. When asked what she would do if she had noted that Resident #1 was in Respiratory distress, she stated she would have suctioned Resident #1 if she needed it. LPN B stated she had recently moved to that unit from the other unit and had not known Resident #1. LPN B was asked what she would do if she encountered a Resident with a stoma having respiratory difficulty. LPN B stated she would take vital signs, assess the Resident's oxygen saturation, and suction the Resident if they needed it. LPN B was asked to show the surveyor the suction machine that she would use at 12:05 PM and she proceeded to the Crash Cart showed the surveyor the device. The surveyor asked her to demonstrate how the device worked, and she gathered the supplies (tubing and suction catheter) and proceeded to the nursing station to plug in the suction machine for a demonstration. The tubing was attached to the canister through ports in the top which was not secured to the canister and the machine did not provide suction. The nurse removed the canister and found the top was not the correct fit for the canister, and proceeded to the supply room to find another top. In the supply room several tops were tried on the canister, and finally the correctly fitting top was applied and returned to the machine which now provided suction at 12:15 PM. LPN A was asked the same question separately from LPN B and she gave a similar answer to LPN B at 12:20 PM. At 12:25 PM Employee A was interviewed in the supply room. She was in charge of supplies on the unit and was found in the supply room placing newly received supplies on the many shelving units. She was asked if Tracheostomy oxygen masks were available on the unit and stated yes. The oxygen delivery neck masks specifically designed for stomas were located in a unopened box of 50 which she stated had arrived in August, and I had not placed them on the shelving units yet. She was asked if there were any open tracheostomy masks and she stated no. When asked how many of these masks were typically used in a month she stated we haven't had a trach since (name) Resident #1. She was asked if they were used for Resident #1, and she stated no, she didn't use oxygen, but we could borrow them from a sister facility if we didn't have any on hand, and needed them. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:45 PM the spouse of Resident #1 was contacted via telephone and interviewed. He stated that the nurses don't know what they are doing, she had that stoma for over [AGE] years and we know it has to be suctioned and cleaned, we did that at home every day, I told them that. He went on to state that the day before she died I told them her stoma needed to be suctioned. The next day around lunchtime before I got there, they called me and told me she was having trouble breathing. He went on to say that upon his arrival around 12:30 PM or 12:45 PM he found Resident #1 with a nasal cannula on her face infusing oxygen, and the Resident had very labored crackly breathing, and no one was in the room with her. The spouse went on to say that Resident #1 only breathed through her stoma and not through her nose, he yelled for help and took the nasal piece off of her nose and placed it over her stoma, but it didn't do any good, she passed away a few minutes after I got there. The spouse went on to say I was panicked and not thinking, I had a pocket knife, I could have cut the 2 nose prongs off and just put the tube in her stoma but I wasn't thinking. Review of physician's orders revealed that the Resident had no oxygen orders, and no suctioning orders. The only order for care of the stoma documented; Stoma, cleanse with normal saline using a lightly damp gauze sponge daily and as needed, Ordered on [DATE]. Review of physician and nursing progress notes revealed the following; Prior to [DATE] there is no indication of problems breathing, other than physician notes stating that the Resident's stoma was uncovered and she had told them that her stoma needed to stay open for her to breathe. This was recorded by physicians multiple times in the progress notes. On [DATE] at 7:35 PM, the call bell was depressed in Resident #1's room and nursing arrived to find the Resident had used a Q-tip to unclog her own stoma and it was stuck in the stoma. The nurse removed the Q-tip and cleaned the stoma. No other notes were documented after [DATE] until the day of [DATE]. On [DATE] the nursing notes documented the following At 12:53 PM, Called to room by LPN and CNA (Certified Nursing Assistant), resident was presenting with a low blood pressure, elevated respirations, and low oxygen saturation of 88% on room air. Resident is not responding to any verbal or tactile stimuli at this time. Hospice (name) notified and resident spouse notified of resident's current clinical state. Resident placed on 2 liters of oxygen via nasal cannula to bring oxygen saturation to 94%. Hospice has dispatched a nurse to come out and evaluate Resident. Will continue to monitor. No further assessment nor monitoring were documented. No assessment was completed for respiratory rate, rhythm or labor, shallow or purse lip breathing, nasal flaring, audible breath sounds, retractions or accessory muscle use, pallor or cyanosis of skin or mucus membranes. No breath sounds were assessed, which could have alerted to mucus or fluid in the lungs, and or stridor which would indicate an obstruction, such as a mucus plug in the trachea. Please refer to the National Institutes of Health (NIH) for further respiratory assessment protocols and standards. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	References from the National Institutes of health revealed that after a total laryngectomy surgery the Patient can no longer breath using the nose or mouth, rather a stoma (surgical hole) placed in the anterior neck is the only way for the Patient to breath. It is further noted that mucus will collect in the trachea and stoma as it no longer can be expectorated through the mouth, and must be removed by way of suctioning the trachea and cleansing the stoma. At 1:12 PM, progress notes documented Resident has expired. Pronounced at 1:06 PM, Hospice and RP (responsible party/spouse) have been notified. Awaiting hospice. At 1:20 PM, the Director of nursing (DON) wrote Resident was observed unresponsive, upon assessment, there were no signs of respiration or pulse. Resident was cold to touch, pupils were fixed. Resident was pronounced 1:06 PM, husband and son were at bedside. Hospice was notified. MD (doctor) had been notified. The Director of Nursing (DON) was the Registered Nurse who Pronounced the Resident expired, however, according to statements made by the Administrator and the Assistant Director of Nursing (ADON) the DON was not involved in care prior to the death. At 2:57 PM, (wrong name) funeral home arrived at 2:56 PM and accepted body. Family at bedside. At 8:21 PM, Ate 25% or less for two or more meals in the day. resident expired. The last entry indicated that the Resident did consume some part of breakfast, and or lunch, on the day she expired as the document did not state the Resident ate 0. The notes do not describe the spouse arriving prior to the death of the Resident nor the interaction with staff during that time when staff were called to the room by him yelling. There is also no description of lung sounds, no apparent attempt to suction the Resident, as the staff were aware that the Resident did experience mucus plugs and would attempt to remove them herself. There was no apparent recognition by the LPN providing care that the nasal cannula oxygen was not infusing oxygen to the Resident's lungs as it was not applied to the stoma by way of a tracheostomy mask. The oxygen saturation documented at 12:53 PM by the LPN would not have been consistent with applying a nasal cannula to the Resident, as the nasal passages no longer communicated with, and supplied oxygen to the lungs after a total laryngectomy. The 12:53 PM note would have been consistent with the spouses account that staff were called to the room by him yelling and the Resident died shortly after that and was pronounced at 1:06 PM, 13 minutes later. Review of the Resident's care plan revealed a focus for a weight loss plan which described crusting and scabbing at stoma site, and a focus for infection control enhanced barrier precautions related to open stoma. These were the only entries in the care plan regarding the Resident's airway. No care plan interventions for cleaning, assessing nor suctioning and oxygen use were derived for the Resident's airway maintenance. There was no individualized nor measurable care care plan for the Resident's airway. Review of hospice notes revealed that the DON at the facility pronounced death, and they were not onsite during the incident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:00 PM, the Administrator was interviewed and stated unfortunately the nurse who was here that day and involved in the Resident's care is on vacation and can't be reached for interview. He further stated he remembered the Resident and her spouse and stated he understood there were problems with the situation. On [DATE], at 2:30 PM, the Administrator and ADON were made aware of the lack of respiratory assessments, suctioning and appropriate oxygen administration leading to harm for Resident #1. They were informed that supplies were in house for appropriate treatment of respiratory care, and the nurses who were interviewed were knowledgeable on respiratory assessments and knew appropriate interventions for this particular scenario, however, in this incident those standards were not followed, and care planning for this individual was insufficient. They stated they knew things had not happened in this situation appropriately and would begin retraining of all nursing staff immediately, and that they had nothing further to provide.

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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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide respiratory care and services to maintain the highest practicable wellbeing for one resident, (Resident #1) in a survey sample of 2 residents resulting in harm for Resident #1. The findings included: For Resident #1, the facility staff failed to assess and monitor the Resident's respiratory status and intervene with appropriate measures prior to the death of the Resident who was suffering labored breathing & respiratory difficulty. No other tracheostomy Residents were residing in the facility at the time of survey so could not be added to the sample. Resident #1 was a discharged Resident so a closed record review was conducted. The Resident was originally admitted to the facility from the hospital on [DATE] with diagnoses including; Acute Osteomyelitis to the right shoulder (primary diagnosis) and a history of Laryngeal cancer with total laryngectomy surgical removal in 1987, anemia, diabetes, hypertension, dementia without behavior disorder, and hospice was ordered on [DATE] with comfort measures and a Do not resuscitate (DNR) order. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of [DATE]. Resident #1 was coded with mild cognitive impairment. Resident #1 required substantial assistance to complete dependence on staff members for activities of daily living. On [DATE] Resident #1's former room mate (Resident #2) was interviewed and found to be alert, and oriented to person, place, time, and situation. The Resident described the friendship that had occurred between herself, Resident #1, and the family of Resident #1 during their time as room mates. She stated that Resident #1's husband brought food to her every day. Resident #2 was asked if suctioning and oxygen were in the room that they shared, and she stated no, she never used oxygen, and she had never seen suctioning completed for Resident #2, and that no machine was kept in the room. She stated that Resident #1's husband would clean her neck stoma everyday, and further stated that the Resident would at times have a partially clogged stoma which gurgled and staff would clean it, but she never saw or heard suctioning. On [DATE] LPN A, and LPN B (Licensed Practical Nurses) were interviewed at the nursing station beginning approximately at 11:45 AM. Both nurses stated they had received training in the care of patients with tracheostomys and stomas, suctioning, administration of oxygen by way of nasal cannulas, masks, emergency CPR, ambu bags, and tracheostomy stoma masks for oxygen delivery, and were able to verbalize the situational uses and applications. Those interviews continue below; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	LPN A stated that she had cared for Resident #1, and Resident #2 and stated that Resident #1 had been alert and interactive and at times could even be combative when she didn't want anyone bothering her. LPN A went on to say both Residents were good cognitively. LPN A was asked if she was working on the day that Resident #1 expired, and she stated she was not caring for Resident #1 that day. When asked what she would do if she had noted that Resident #1 was in Respiratory distress, she stated she would have suctioned Resident #1 if she needed it. LPN B stated she had recently moved to that unit from the other unit and had not known Resident #1. LPN B was asked what she would do if she encountered a Resident with a stoma having respiratory difficulty. LPN B stated she would take vital signs, assess the Resident's oxygen saturation, and suction the Resident if they needed it. LPN B was asked to show the surveyor the suction machine that she would use at 12:05 PM and she proceeded to the Crash Cart showed the surveyor the device. The surveyor asked her to demonstrate how the device worked, and she gathered the supplies (tubing and suction catheter) and proceeded to the nursing station to plug in the suction machine for a demonstration. The tubing was attached to the canister through ports in the top which was not secured to the canister and the machine did not provide suction. The nurse removed the canister and found the top was not the correct fit for the canister, and proceeded to the supply room to find another top. In the supply room several tops were tried on the canister, and finally the correctly fitting top was applied and returned to the machine which now provided suction at 12:15 PM. LPN A was asked the same question separately from LPN B and she gave a similar answer to LPN B at 12:20 PM. At 12:25 PM Employee A was interviewed in the supply room. She was in charge of supplies on the unit and was found in the supply room placing newly received supplies on the many shelving units. She was asked if Tracheostomy oxygen masks were available on the unit and stated yes. The oxygen delivery neck masks specifically designed for stomas were located in a unopened box of 50 which she stated had arrived in August, and I had not placed them on the shelving units yet. She was asked if there were any open tracheostomy masks and she stated no. When asked how many of these masks were typically used in a month she stated we haven't had a trach since (name) Resident #1. She was asked if they were used for Resident #1, and she stated no, she didn't use oxygen, but we could borrow them from a sister facility if we didn't have any on hand, and needed them. On [DATE] at 12:45 PM the spouse of Resident #1 was contacted via telephone and interviewed. He stated that the nurses don't know what they are doing, she had that stoma for over [AGE] years and we know it has to be suctioned and cleaned, we did that at home every day, I told them that. He went on to state that the day before she died I told them her stoma needed to be suctioned. The next day around lunchtime before I got there, they called me and told me she was having trouble breathing. He went on to say that upon his arrival around 12:30 PM or 12:45 PM he found Resident #1 with a nasal cannula on her face infusing oxygen, and the Resident had very labored crackly breathing, and no one was in the room with her. The spouse went on to say that Resident #1 only breathed through her stoma and not through her nose, he yelled for help and took the nasal piece off of her nose and placed it over her stoma, but it didn't do any good, she passed away a few minutes after I got there. The spouse went on to say I was panicked and not thinking, I had a pocket knife, I could have cut the 2 nose prongs off and just put the tube in her stoma but I wasn't thinking. (continued on next page)

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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 0695 Level of Harm - Actual harm Residents Affected - Few	Review of physician's orders revealed that the Resident had no oxygen orders, and no suctioning orders. The only order for care of the stoma documented; Stoma, cleanse with normal saline using a lightly damp gauze sponge daily and as needed, Ordered on [DATE]. Review of physician and nursing progress notes revealed the following; Prior to [DATE] there is no indication of problems breathing, other than physician notes stating that the Resident's stoma was uncovered and she had told them that her stoma needed to stay open for her to breathe. This was recorded by physicians multiple times in the progress notes. On [DATE] at 7:35 PM, the call bell was depressed in Resident #1's room and nursing arrived to find the Resident had used a Q-tip to unclog her own stoma and it was stuck in the stoma. The nurse removed the Q-tip and cleaned the stoma. No other notes were documented after [DATE] until the day of [DATE]. On [DATE] the nursing notes documented the following At 12:53 PM, Called to room by LPN and CNA (Certified Nursing Assistant), resident was presenting with a low blood pressure, elevated respirations, and low oxygen saturation of 88% on room air. Resident is not responding to any verbal or tactile stimuli at this time. Hospice (name) notified and resident spouse notified of resident's current clinical state. Resident placed on 2 liters of oxygen via nasal cannula to bring oxygen saturation to 94%. Hospice has dispatched a nurse to come out and evaluate Resident. Will continue to monitor. No further assessment nor monitoring were documented. No assessment was completed for respiratory rate, rhythm or labor, shallow or purse lip breathing, nasal flaring, audible breath sounds, retractions or accessory muscle use, pallor or cyanosis of skin or mucus membranes. No breath sounds were assessed, which could have alerted to mucus or fluid in the lungs, and or stridor which would indicate an obstruction, such as a mucus plug in the trachea. Please refer to the National Institutes of Health (NIH) for further respiratory assessment protocols and standards. References from the National Institutes of health revealed that after a total laryngectomy surgery the Patient can no longer breath using the nose or mouth, rather a stoma (surgical hole) placed in the anterior neck is the only way for the Patient to breath. It is further noted that mucus will collect in the trachea and stoma as it no longer can be expectorated through the mouth, and must be removed by way of suctioning the trachea and cleansing the stoma. At 1:12 PM, progress notes documented Resident has expired. Pronounced at 1:06 PM, Hospice and RP (responsible party/spouse) have been notified. Awaiting hospice. At 1:20 PM, the Director of nursing (DON) wrote Resident was observed unresponsive, upon assessment, there were no signs of respiration or pulse. Resident was cold to touch, pupils were fixed. Resident was pronounced 1:06 PM, husband and son were at bedside. Hospice was notified. MD (doctor) had been notified. The Director of Nursing (DON) was the Registered Nurse who Pronounced the Resident expired, however, according to statements made by the Administrator and the Assistant Director of Nursing (ADON) the DON was not involved in care prior to the death. (continued on next page)

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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 0695 Level of Harm - Actual harm Residents Affected - Few	At 2:57 PM, (wrong name) funeral home arrived at 2:56 PM and accepted body. Family at bedside. At 8:21 PM, Ate 25% or less for two or more meals in the day. resident expired. The last entry indicated that the Resident did consume some part of breakfast, and or lunch, on the day she expired as the document did not state the Resident ate 0. The notes do not describe the spouse arriving prior to the death of the Resident nor the interaction with staff during that time when staff were called to the room by him yelling. There is also no description of lung sounds, no apparent attempt to suction the Resident, as the staff were aware that the Resident did experience mucus plugs and would attempt to remove them herself. There was no apparent recognition by the LPN providing care that the nasal cannula oxygen was not infusing oxygen to the Resident's lungs as it was not applied to the stoma by way of a tracheostomy mask. The oxygen saturation documented at 12:53 PM by the LPN would not have been consistent with applying a nasal cannula to the Resident, as the nasal passages no longer communicated with, and supplied oxygen to the lungs after a total laryngectomy. The 12:53 PM note would have been consistent with the spouses account that staff were called to the room by him yelling and the Resident died shortly after that and was pronounced at 1:06 PM, 13 minutes later. Review of the Resident's care plan revealed a focus for a weight loss plan which described crusting and scabbing at stoma site, and a focus for infection control enhanced barrier precautions related to open stoma. These were the only entries in the care plan regarding the Resident's airway. No care plan interventions for cleaning, assessing nor suctioning and oxygen use were derived for the Resident's airway maintenance. There was no individualized nor measurable care care plan for the Resident's airway. Review of hospice notes revealed that the DON at the facility pronounced death, and they were not onsite during the incident. On [DATE] at 2:00 PM, the Administrator was interviewed and stated unfortunately the nurse who was here that day and involved in the Resident's care is on vacation and can't be reached for interview. He further stated he remembered the Resident and her spouse and stated he understood there were problems with the situation. On [DATE], at 2:30 PM, the Administrator and ADON were made aware of the lack of respiratory assessments, suctioning and appropriate oxygen administration leading to harm for Resident #1. They were informed that supplies were in house for appropriate treatment of respiratory care, and the nurses who were interviewed were knowledgeable on respiratory assessments and knew appropriate interventions for this particular scenario, however, in this incident those standards were not followed, and care planning for this individual was insufficient. They stated they knew things had not happened in this situation appropriately and would begin retraining of all nursing staff immediately, and that they had nothing further to provide.