STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents care plans were reviewed and revised for 1 Resident (#2) in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to review and revise the care plan after the Resident exited the through a window in his room while on 1:1 supervision for exit seeking behavior. Resident #2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia, mood disorder and hypertension, paranoid personality, and anxiety. Resident #2's BIMS (Brief Interview of Mental Status) score on admission was 4/15 indicating severe cognitive impairment. Resident #2's most Minimum Data Set with an ARD (Assessment Reference Date) of 9/4/24 scored Resident #2 as having a BIMS of 1/15. The clinical record that Resident #2 was placed on 1:1 supervision for exiting seeking behaviors 5/28/24. On 7/12/24 at approximately 7 p.m. Resident #2 was able to manipulate the window in his room and crawl out of it while on 1:1 observation. On 10/1/24 an interview was conducted with the ADON who stated that care plans should be updated quarterly, annually and with changes in care and condition of the Resident. She also stated that she believed the care plan had been updated after the incident on 7/12/24. On 10/1/24 a review of the clinical record revealed the following items related to elopement and safety of the exit seeking Resident: FOCUS: I look for exits and am at risk for leaving the facility. Date Initiated: 05/28/2024 GOAL: I will not leave the facility unattended through my next care plan review. Date Initiated: 05/28/2024 Revision on: 09/11/2024 Target Date: 09/16/2024 INTERVENTIONS: Elopement Risk assessment per protocol. Date Initiated: 05/28/2024 (continued on next page)

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	Personal wander prevention device if necessary: check for placement each shift and check for proper function daily. Date Initiated: 05/28/2024 S Redirect resident from doors areas of exit. Date Initiated: 05/28/2024 FOCUS: At risk for elopement related to senile degeneration of the brain Date Initiated: 05/28/2024 GOAL: Patient will have no incidence of elopement Date Initiated: 05/28/2024 Revision on: 09/11/2024 Target Date: 09/16/2024 Will remain safe during placement at Living Center Date Initiated: 05/28/2024 Revision on: 09/11/2024 Target Date: 09/16/2024 INTERVENTIONS: 1:1 monitoring Date Initiated: 05/28/2024 Assess for risk of elopement per living center policy Date Initiated: 05/28/2024 Educate family/responsible party on talking positively about Living Center Placement Date Initiated: 05/28/2024 Encourage family to bring in personal possessions Date Initiated: 05/28/2024 Evaluate effect of cognitive impairment upon resident's ability to understand changes in surroundings Date Initiated: 05/28/2024 Introduce patient to other patients in the Living Center Date Initiated: 05/28/2024 Involve patient in preferred activities Date Initiated: 05/28/2024 Involve the patient in decision making regarding daily choices Date Initiated: 05/28/2024 Redirect patients from doors Date Initiated: 05/28/2024 Take picture of patient upon admission for identification for updating elopement book Date Initiated: 05/28/2024 Wander-guard intact as tolerated Date Initiated: 05/28/2024 On 10/1/24 during the end of day meeting the Administrator was made aware of the incident and no further information was provided.

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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** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure each Resident receives adequate supervision to prevent accidents, for 1 Resident (#2) in a survey sample of 5 Residents. The findings included: For Resident #2 the facility staff failed to ensure adequate supervision resulting in Resident #2 exiting through a window in his room while on 1:1 supervision. Resident #2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia, mood disorder and hypertension, paranoid personality, and anxiety. Resident #2's BIMS (Brief Interview of Mental Status) score on admission was 4/15 indicating severe cognitive impairment. Resident #2's most Minimum Data Set with an ARD (Assessment Reference Date) of 9/4/24 scored Resident #2 as having a BIMS of 1/15. The clinical record that Resident #2 was placed on 1:1 supervision for exiting seeking behaviors on 5/28/24. On 9/30/24 Resident #2 was observed walking briskly around the nurses station on A wing. Resident #2 was unable to be interviewed due to cognitive status. Resident #2 has no physical impairments to his limbs is able to ambulate without assistance of wheelchair, walker, can or physical assistance. On 9/30/24 during initial tour a random sample of 3 windows on each unit was selected and attempted to open. None of the windows on the units were able to open more than 5-6 inches. A review of the clinical record revealed the following progress notes: 7/12/24 7:18 p.m. - Situation: Background: Assessment: Resident did not have any signs or symptoms of any distress noted ROM [Range of Motion] WNL [Within Normal Limits] to all extremities, some agitation noted but easily redirected. Superficial scratches noted on neck area, face and left forearm. 7/12/24 8:18 p.m. Situation: Nurse from another unit alerted nurses that CNA for one-to-one monitoring stated the resident got out of his room window Background: Senile degeneration of brain, other frontotemporal neurocognitive disorder. Assessment: Nurses arrived at the residents room and note the window and window screen off of the window frame. The nurse looked out the window and noted resident outside of his window, resident was called to return to the window and was easily redirected by staff and assisted back into the resident room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Response: Supervisor, ADON and MD made aware. One to one caregiver was changed, and supervisor sat with the resident until the new CNA arrived. RP made aware. The following is an excerpt from the NP (Nurse Practitioner) note 7/16/24 10:41 a.m. - Asked to see patient for evaluation due to reports of restlessness and agitation. Staff reports that patient was noted to have recently manipulated the window in his room and attempted to exit the building via his window. Staff was sigh [sic] and intervened. There were no acute injuries. Patient is seen today of ambulating. He is a poor historian but appears in no acute distress, is not vocalizing any complaints to this provider. On 10/1/24 at approximately 11:00 AM an interview was conducted with the NP who stated that she was made aware of the incident that happened 7/12/24. She stated that she saw him after the incident and entered a note into the chart. She stated that the Resident had minor scratches. She stated that she was told the Resident had been within eyesight of the staff at all times. When asked if she was aware that the Resident was on 1:1 monitoring she stated that she was. She stated that the Resident was on Hospice and them (Hospice) had adjusted his medications since then and that Resident #2 has been much calmer and has had no more incidents like this one since July. The NP stated that he is now on Q15's (every 15 minute) checks instead of 1:1 since his behaviors have decreased. On 10/1/24 at 11:21 AM an interview with RN B was conducted, and she stated that the incident happened at change of shift (7p.m.) she stated she and the off going nurse were in the med room counting the cart, when staff alerted her that Resident #2 had gone out his room window. She stated that she went to the room with the off going nurse and they got Resident #2 inside safely. She stated that the attempts to ask the 1:1 CNA what happened were ineffectual due to language barrier. RN B stated she did not understand why he did not stop him from going out the window. When asked if the window was shattered or glass was broken, she stated that it was not. RN B stated that the Resident had taken the window off the track and busted out the screen. When asked if Resident #2 was injured she stated that he was not. When asked if she notified the MD and Responsible Party, she stated that she did but that it was a weekend, and she also notified the supervisor who notified the ADON. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at approximately 12:45 an interview was conducted with Employee D, who was asked to demonstrate how the windows open. Employee D stated that the windows slide to the side to open, however they have stopper on them to prevent them being opened more than 5 inches. When asked why this is Employee D stated, This is a safety measure to prevent elopement or suicide. Employee D demonstrated how the windows operate. Employee D was asked if he has had any broken windows in the facilities in past 6 months, he stated that he has not. When asked has he had any windows that have come off track he stated that he did, and he indicated that in July there was one on A Wing that had to be put back on track. When asked about that he stated that Resident #2 is physically in good condition and was able to manipulate the window off track. He stated that once he had it off the track, he set it down without breaking it and was able to get out of the screen to the outside. The Resident's room is ground floor level, and he was able to climb out of the window without injury. Employee D stated that he was aware that this Resident was on a wanderguard and had 1:1 staff. Employee D stated that there have been no other incidents regarding windows since this happened in July. When asked if there had been any incidents involving windows with Residents other than Resident #2, he stated, There have not been any incidents that he can remember before this one and none since. Employee D state he has been working at this facility for 5 years. Employee D stated that unless you know what you are doing these windows are not easy to remove from the track. Employee D demonstrated the removal of the window from the track the window is estimated to weight 30-40 lbs. When asked why they would be removed other than to replace them he stated that is how they clean them. On 10/1/24 a review of the clinical record revealed that Resident #2 was a retired custodial / janitorial worker. This fact may explain why even with a BIMS score of 4 he was able to easily manipulate the window through the use of muscle memory. Three attempts to contact the CNA that was on duty the day of this incident were unsuccessful. A review of the incident reports revealed the following excerpts from the ADON's statement. I asked [CNA D name redacted] to give me a statement in detail as to what happened with [Resident #2 name redacted]. [CNA name redacted] said that [Resident #2 name redacted] started to become agitated so he wants to the doorway to yell for help and upon turning around [Resident #2 name redacted] had the window and screen off and went out the window. Resident was brought back in. He didn't get anywhere. I informed [CNA name redacted] that he was suspended pending investigation. A review of the investigation into the incident revealed the following Policy with regard to supervision: Policy: Resident safety checks can be initiated by physician or Clinical Nurse who deems a resident to be at risk to self or others. Procedure: 1. Initiate Resident Safety Checks form with intervals designated by physician or Clinical Nurse noting reason for form. 2. Check resident at required intervals. 3. Initial form indicating check was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Form is filed in medical record. For residents exhibiting serious behaviors (not limited to aggression, physical aggression, sexual behaviors, and suicide ideation) Safety Checks in increments are not appropriate if these behaviors exist it is appropriate to initiate one to one until an appropriate intervention is implemented. (Psych consult, transfer out for mental health services, change in medication, seen by physician or other appropriate interventions.) After the event on 7/12/24 all staff were educated on de-escalation of behaviors. The following 1:1 education was provided to all nursing staff. The following educational requirement concerning 1:1 assignments 1) When assigned to 1:1 patient, you are to be t an arm's length at all times. 2) The caregiver (CNA) assigned is responsible for all documentation during their shift 3) The CNA assigned to resident must have relief during breaks (resident is never to be left unattended) 4) The CNA assigned to resident is responsible for all ADL care. On 10/1/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free of significant medication errors for 2 Residents (#'s 1 & 3) in a survey sample of 5 Residents. The findings included: 1. For Resident #1 the facility staff failed to ensure insulin (both long-acting and short-acting) were administered per physician orders. On 10/1/24 a review of the clinical record revealed that Resident #1 had 2 orders for insulin. Resident #1 had orders for a long-acting insulin given twice a day and a short-acting insulin given prior to meals. The long- acting insulin orders were as follows: Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 Unit/ml [units per milliliter] Inject 37 unit subcutaneously two times a day related to Type 2 diabetes. Order Date-08/14/2024 This long-acting insulin was ordered for 9:00 a.m. and 9:00 p.m. A review of the MAR (Medication Administration Record) revealed the order times and the administration times. The following is a list of times that this order was not following in August and September of 2024. 8/24/24 9:00 a.m. given at 3:42 p.m. 9/14/24 9:00 a.m. given at 12:10 p.m. 9/28/24 9:00 a.m. given at 12:07 p.m. The short- acting insulin orders were as follows: Insulin Lispro Injection Solution 100 Unit/ml [units per milliliter]. Inject 35 unit subcutaneously before meals related to Type 2 Diabetes -Order Date- 08/15/2024 This short-acting insulin was ordered for 7:30 a.m. 11:30 a.m. and 4:30 p.m. A review of the MAR (Medication Administration Record) revealed the order times and the administration times. The following is a list of times that this order was not following in August and September of 2024. 8/04/24 4:30 p.m. given at 6:02 p.m. 8/19/24 7:30 a.m. given at 9:06 a.m. 8/24/24 7:30 a.m. given at 3:42 p.m. 8/29/24 7:30 a.m. given at 9:04 a.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/01/24 7:30 a.m. given at 8:54 a.m. 9/02/24 7:30 a.m. given at 9:52 a.m. 9/02/24 11:30 a.m. given at 2:09 p.m. 9/02/24 4:30 p.m. given at 3:56 p.m. [**Note this is less than 2 hours from the prior dose] 9/03/24 7:30 given at 9:35 a.m. 9/05/24 11:30 09/05/24 3:51 p.m. 9/24/24 7:30 given at 9:40 a.m. 9/24/24 11:30 given at 12:52 p.m. 925/24 7:30 given at 10:49 a.m. 9/29/24 7:30 given at 10:21 a.m. 9/30/24 7:30 given at 9:07 a.m. On 10/1/24 at approximately 11:00 a.m. an interview with the Unit manager on B Wing was conducted who stated that nurses should always follow physician orders with regard to medication administration. She stated if there is a question they need to reach out to the practitioner for clarification. If a Resident refuses or there is an issue, they should notify the physician. When asked if there is a delay in a medication being given what should the nurse do, she stated Nurses should reach out to the provider when a medication is going to be late, especially one that is given multiple times a day. The physician may want to hold the next dose or change the schedule of doses depending on the medication. On 10/1/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 2. For Resident #1 the facility staff failed to ensure Trulicity (GLP 1 Receptor Agonist -Diabetes Medication) was administered per physician orders. On 10/1/24 a review of the clinical record revealed that Resident #3 had orders that read: Trulicity Subcutaneous Solution Pen injector 0.75 MG/0.5ML Inject 0.75 mg subcutaneously one time a day every Wed related to Diabetes Mellitus 08/20/2024 A review of the MAR (Medication Administration Record) revealed that Trulicity had been coded as #3 (See Nurses Note) upon looking in the progress notes 8/22/24 at 10:35 a.m. an entry was made into the progress notes that the medication was On order. On 9/4/24 once again the same information was entered. There were no notes indicating notification of physician or Resident. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at approximately 11:00 a.m. an interview with the Unit manager on B Wing was conducted who stated that nurses should always follow physician orders with regard to medication administration. She stated if there is a question they need to reach out to the practitioner for clarification. If a Resident refuses or there is an issue, they should notify the physician. When asked if there is a delay in a medication being given what should the nurse do, she stated Nurses should reach out to the provider when a medication is going to be late, especially one that is given multiple times a day. The physician may want to hold the next dose or change the schedule of doses depending on the medication. On 10/1/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.