

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Northampton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1028 Topping Lane Hampton, VA 23666	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47299</p> <p>Based on staff interview, clinical record review and facility document review, the facility staff failed to maintain a complete and accurate medical record for one of 35 residents in the closed record sample, resident # 311.</p> <p>The findings included:</p> <p>Resident # 311's diagnoses included but were not limited to muscle weakness, osteoarthritis, bradycardia, and dementia. The minimum data set (MDS) with an assessment reference date of 11/29/22 assigned the resident a brief interview for mental status score of 3 out of 15 indicating the resident had severe cognitive impairment. According to the MDS data the resident was dependant for transfers and non-ambulatory without at least extensive assistance.</p> <p>The care plan for resident # 311 was reviewed. A problem statement read, (resident) has a potential to fall (High Risk) R/T: Reduced mobility, History of falls and poor safety awareness, Impulsive behavior, Dementia- cognitive impairment, restlessness.</p> <p>During a review of the progress notes, the following was noted on 1/16/24 at 6:40 AM, resident up through the night</p> <p>and continue to try and get up out of chair resident did not sleep at all. resident place at nursing station will continue to assess. The next note was made on 1/19/23 at 4:29 PM and read, Called to the room by patients Certified Aide to assess patients left arm. Upon observation her arm was edematous and bruised just below the shoulder to the elbow. Upon lifting her arm laterally with support patient leaned towards the left arm and showed signs of discomfort. Director of Nursing made aware and undersigned paged on call medical service. An order was given for an x-ray of the arm and a progress note dated 1/20/23 at 1:19 AM that read, Undersigned called Dynamic Mobile Imaging for patients results of left shoulder x-ray. It was reported that the patient has an acute fx and that the results will be faxed over first then called to staff. Night shift nurse made aware of pending fax and that imaging service will call when faxing as been processed. The resident was sent per physician's order to the emergency room at a local hospital and returned to the facility the same day with a sling on the arm and an order to follow up with an orthopedist.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24 at 10:55 AM this surveyor interviewed the Director of Nursing (DON) who recalled resident #311 and this incident. They stated, I wasn't notified of the fall until 1/19/23 when the nurse came and got me because she was going to do a blood pressure and saw the swelling and bruising. She said to me well, you know she fell the other day. I told her no, there was nothing in the notes about a fall. I went and looked at the resident and did an investigation and that is what I attributed the injury to. She had a history of fragility fractures and osteoporosis. The injury wasn't suspicious because it was in a location that would be vulnerable to fracture from a fall especially considering her osteoporosis.</p> <p>The investigation conducted by the facility was provided. The investigation included a time line, witness statements, a copy of the x-ray report and a summary that read in part, It was determined that the injury was caused by the fall that occurred on 1/15-1/16/23 11-7 shift, this incident was not considered reportable due to that reason.</p> <p>This surveyor reviewed the policy entitled, Fall Management which read in part, Documentation: All falls are documented in the resident record, to include if applicable, the following objective and factual statements regarding: Circumstances at time of fall- For an unwitnessed fall, the record reflects the resident's statement with quotes if the resident is able to state what happened- For an unwitnessed fall, notes indicate the resident's location, position, and condition upon staff arrival-For an unwitnessed fall, notes indicate the resident's activity prior to the fall and other precipitating factors- Results of assessment and condition of the resident- care rendered- Notification of physician, resident representative and emergency room transport company (if utilized)- Physician orders- Interventions implemented to minimize future falls.</p> <p>10/02/24 02:13 PM this surveyor interviewed Licensed Practical Nurse (LPN) # 1. They stated they were the nurse caring for resident # 311 on the night of 1/16/23. They stated, It was on 11-7 I was at the desk and she came scooting out in the hall on her bottom. We put her in a chair and left her at the desk because she was very active all night. I assessed her there wasn't any bruising or swelling her ROM was good, she was able to lift her arms and her grips were equal. When asked to confirm there were no injuries assessed directly after the fall they stated, no, she wasn't injured that I could tell. Surveyor asked if resident could have indicated if they were in pain and they stated, she could answer yes or no questions and I asked her, she didn't say anything about pain. She didn't show any grimaces or anything and had a nice firm grip. We had to keep repositioning her in the chair all night because she kept trying to get up and she wasn't able to walk or anything. When asked if she notified the RP or MD she stated, It was really late, I waited until morning. If I had known there was an injury, I would have called the on call. When asked about the lack of any notes surrounding the fall, they stated, I was just so preoccupied with keeping her safe, she was really agitated and continuously trying to get up and that took up most of my night. I honestly never even remembered that I didn't put the first note in about the fall.</p> <p>On 10/3/24 at 3:37 PM the survey team met with the [NAME] President of Quality the DON and the [NAME] President of Nursing Services. This concern was discussed with them at that time.</p> <p>No further information was provided to the survey team prior to the exit conference.</p>		