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	495173	A. BUILDING _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted onsite on 9/8/21 through 9/9/21 and continued offsite review through 9/10/21. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Focused Infection Control (FIC) survey was conducted 09/08/21 through 09/10/21. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Resident cumulative COVID-19 cases since 2020 totaled 42, 3 COVID-19 related deaths. Staff cumulative COVID-19 cases since 2020 totaled 42, all staff recovered and no deaths. At the time of the survey, there were currently 9 Residents that tested positive for COVID-19, and 10 Staff that tested positive for COVID-19. Two (2) complaints were investigated during the survey: VA00051411, Substantiated, with no deficiencies; VA00048585, Substantiated with deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 197 certified bed facility was 100 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Resident #1 through 12) and 11 closed record reviews (Resident #13 through 23).	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/4/21

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.

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F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, documentation review and the facility policy, the facility staff failed to meet professional standards of quality and provide an ongoing assessment and monitoring after an unwitnessed fall for 5 of 23 residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #23) in the survey sample. The findings included: 1. Resident #1 was admitted to the nursing facility on 11/03/15. Diagnosis for Resident #1 included but not limited to Repeated Falls and Anxiety. Resident #1's Minimum Data Set (MDS - an assessment protocol) an annual with an Assessment Reference Date (ARD) of 08/12/21 coded Resident #1 Brief Interview for Mental Status (BIMS) with a 13 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #1 independent with no supervision or physical setup from staff with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing for Activities of Daily Living (ADL) care. The care plan identified Resident #1 with an unwitnessed fall on 11/20/19 without any apparent injuries. The goal set for the resident by the staff to be without complications related to fall. Some	F 658	1. Resident #1 had a monthly assessment completed 9/23/2021 to include neuro checks with no apparent concerns. Resident #2 was discharged on 11/13/2020. Resident #3 had a monthly assessment completed on 9/10/2021 to include neuro checks with no apparent concerns. Resident #4 had a monthly assessment completed on 9/19/2021 to include neuro checks with no apparent concerns. Resident #23 discharged on 1/22/2020. 2. DON/Designee will conduct quality review of all residents who have had a fall from 8/15/21 to 9/15/21 to review neuro checks for completion and report any altered findings to the MD for further evaluation if necessary. 3. DON/Designee provided education to LPNs and RNs on fall process to include neuro checks. 4. DON/Designee to complete monitoring for residents with falls, 5x a week for 12 weeks to ensure neurological checks are completed. Results of audits will be taken to QAPI committee monthly X3 for review and revision as needed. 5. Date of Compliance: October 4, 2021	

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of the interventions/approaches the staff would use to accomplish this goal offer assistance to the resident with toileting prior to going to bed and Occupational Therapy (OT) to evaluate.

The Fall Risk Assessment dated 09/29/19 assessed the residents score as a 12. A score of 10 or more indicates a High Risk for falls.

Review of the clinical nurse's notes evidenced an entry dated 11/20/19 at 10:29 p.m. The nurse documented she heard a scream from the resident's bathroom (door was closed)...this nurse opened the bathroom door observed the resident on the floor lying on her right side. Vital signs (VS): (BP) 115/67, (P) 67, (R) 22, (T) 98.5, and oxygen saturation 99% on room air.
The resident did not complain of pain, able to move extremities without difficulty. The clinical note also included the following recommendations: continue to monitor and post fall process per protocol.

Review of Resident #1's clinical record revealed neurological assessment was initiated and started on 11/20/19 at approximately 10:30 p.m., related to an unwitnessed fall. The frequency of neurological assessments was scheduled for every 15 minutes x 4; then every 30 minutes x 4; then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7 then stop. The clinical record revealed during the every 8 hours x 7 neurological assessments, Resident #2 was only assessed 4 times out of the 7 assessments.

2. Resident #2 was admitted to the nursing facility on 07/18/19. Diagnosis for Resident #2 included but not limited to Dementia with behavioral disturbances, history of falling and

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Anxiety disorder. Resident #2's Minimum Data Set (MDS - an assessment protocol) a quarterly with an Assessment Reference Date (ARD) of 10/03/20 coded Resident #2 Brief Interview for Mental Status (BIMS) with a 12 out of a possible score of 15 indicating moderate cognitive impairment. The MDS coded Resident #2 supervision with setup help only with bed mobility, transfer, dressing, eating and toilet use, supervision with limited assistance of one with personal hygiene and independent with no supervision with bathing for Activities of Daily Living (ADL) care.

The care plan identified Resident #2 with an unwitnessed fall on 11/07/19 without any apparent injuries. The goal set for the resident by the staff was that the resident will be free from complications. One of the interventions/approaches the staff would use to accomplish this goal was to encourage resident to use call light if assistance is needed.

The Fall Risk Assessment dated 09/04/19 assessed the residents score as a 6. Another assessment was completed on 11/07/19 assessed the residents score as a 12. A score of 10 or more indicates a High Risk for falls.

Review of the clinical nurse's notes evidenced an entry dated 11/07/19 at 2:35 p.m. The nurse documented Resident #2 was observed with her hands and knees on the floor. The clinical note indicated that the fall was an unwitnessed fall and the resident said she was trying to go bed. The resident's hands, knees or any other part to the body assessed with no injuries noted. VS: (BP) 113/56, (P) 66, (R) 18, (T) 97.8, and oxygen saturation 97% on room air. The note revealed

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resident did not complain of pain andwas able to move extremities without difficulty. The clinical note also included neuro checks in progress as ordered.

Review of Resident #2's clinical record revealed neurological assessment was initiated and started on 11/07/19 at approximately 2:30 p.m., related to an unwitnessed fall. The frequency of neurological assessments was scheduled for every 15 minutes x 4; then every 30 minutes x 4; then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7. The clinical record documented Resident #2 was only assessed once out of the every 4 hours x 4 assessments and was never assessed during the 8 hours x 7 assessments.

3. Resident #3 was originally admitted to the nursing facility on 02/05/14. Diagnosis for Resident #3 included but not limited to Cardiovascular Disease (CVA - stroke) and muscle weakness. Resident #3's Minimum Data Set (MDS - an assessment protocol) an quarterly with an Assessment Reference Date (ARD) of 07/13/21 coded Resident #3 Brief Interview for Mental Status (BIMS) a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making. The MDS coded the resident total dependence of one with bathing, extensive assistance of one with bed mobility and toilet use, activity only occurred with one assist with with transfer and dressing. Under section G-0400 (Functional limitation in Range of Motion (ROM) was coded for impairment on both side to bilateral lower extremities.

The care plan identified Resident #3 with an

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unwitnessed fall on 11/26/19 without any apparent injuries. The goal set for the resident by the staff was that the resident will be free from complications. One of the interventions/approaches the staff would use to accomplish this goal was to encourage resident to use call light if assistance is needed.

The Fall Risk Assessment dated 08/15/19 assessed the residents score as a 14. A score of 10 or more indicates a High Risk for falls.

Review of the nurse's notes evidenced an entry dated 11/26/19 at 6:47 a.m. The nurse documented Resident #3 was observed on the floor at 6:30 a.m., (VS) (BP) 138/68, (P) 76, (R) 18. The nurse's note indicated the resident woke up and was on the floor,

Review of Resident #3's clinical record revealed neurological assessment was initiated and started on 11/26/19 at approximately 6:30 a.m., related to an unwitnessed fall. The frequency of neurological assessments was scheduled for every 15 minutes x 4; then every 30 minutes x 4; then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7. The clinical record documented Resident #3 was only assessed twice during the every 4 hours x 4 assessments, and was never assessed during the every 8 hours x 7 assessments.

4. Resident #4 was originally admitted to the nursing facility on 11/23/19. Diagnosis for Resident #4 included but not limited to Dementia with behavioral disturbances, history of falling and muscle weakness. Resident #4's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date

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(ARD) of 07/25/21 coded Resident #4's Brief Interview for Mental Status (BIMS) a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making.

The care plan identified Resident #4's with an unwitnessed fall on 12/23/19 without any apparent injuries. The goal set for the resident by the staff was that the resident will be free from pain related to fall. One of the interventions/approaches the staff would use to accomplish this goal was to place Dycem in the resident's wheelchair.

The Fall Risk Assessment dated 11/30/19 assessed the residents score as a 11. A score of 10 or more indicates a High Risk for falls.

Review of the clinical nurse's note evidenced an entry dated 12/23/19 at 6:02 p.m. The nurse documented the Certified Nursing Assistant (CNA) informed her that Resident #4 had an unwitnessed fall in the activity room. The nurse note indicated that the resident fell from her wheel chair and was lying flat on the floor with her eyes open. The resident did not complain of any pain. (VS): (BP) 169/91, (P) 101, (R) 18, (T) 96.6, and oxygen saturation 89 on room air. The note documented Resident #4 has an order for oxygen at 4 liters/min via nasal cannula but the oxygen was not in her nares when found by the staff.

Review of Resident #4's clinical record revealed neurological assessment was initiated and started on 12/23/19 at approximately 5:00 p.m., related to an unwitnessed fall. The frequency of neurological assessments was scheduled for every 15 minutes x 4; then every 30 minutes x 4;

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then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7. The clinical record revealed during the every 8 hours x 7 assessments, only one of the assessments were completed.

5. Resident #23 was admitted to the nursing facility on 09/19/19. Diagnosis for Resident #23 included but not limited to Dementia with behavioral disturbances. Resident #23's Minimum Data Set (MDS - an assessment protocol) a significant change with an Assessment Reference Date (ARD) of 12/27/19 coded Resident #23 Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. The MDS coded Resident #23 total assistance of two with bed mobility, dressing, eating, toilet use personal hygiene and bathing for Activities of Daily Living (ADL) care.

The care plan identified Resident #23 with an unwitnessed fall on 11/20/19 without any apparent injuries. The goal set for the resident by the staff to be without complications related to fall. Some of the interventions/approaches the staff would use to accomplish this goal is to offer assistance to the resident with toileting prior to going to bed and Occupational Therapy (OT) to evaluate.

The Fall Risk Assessment dated 10/02/19 assessed the residents score as a 18. A score of 10 or more indicates a High Risk for falls.

Review of the nurse's note evidenced an entry dated 11/21/19 at 3:25 p.m. The nurse documented the Certified Nursing Assistant (CNA) informed her on the same day at 2:45

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p.m., that Resident #23 was lying on floor mats on the right side of the bed; no apparent injuries noted. (VS): (BP) 137/68, (P) 82, (R) 18, (T) 97.7 and oxygen saturation 97% on room air.

Review of Resident #23's clinical record revealed neurological assessment was initiated and started on 11/21/19 at approximately 3:00 p.m., related to an unwitnessed fall. The frequency of neurological assessments was scheduled for every 15 minutes x 4; then every 30 minutes x 4; then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7. The clinical record revealed during the every 8 hours x 7 assessments, none of the assessments were completed.

An interview was conducted with the Director of Nursing (DON) on 09/10/21 at approximately 9:45 a.m. The DON stated, "The expectations is for the nurse's to complete the entire neurological assessment as it appears in Point Click Care (PCC).

On 09/10/21 at approximately 4:20 p.m., a pre-exit meeting was held with the Administrator, Director of Nursing, Regional Nurse Consultant and Education Specialist. No additional information was provided.

The facility's policy titled Fall Prevention and Management Policy - revision date 12/09/19. Residents will be assessed for fall risk(s) on admission, quarterl, after any falls, and as needed.

The facility's policy titled Neurological Checks Policy - revision date 05/27/21.
Polivy: Neurological checks are indicated to

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monitor for potential irregularities in neurological status in the event of know or unknown head trauma as the result of a resident event, change in resident condition, or physician's orders.

Procedure (General Guidelines)
A.) An initial neurological check will be performed by a licensed clinician for all residents who have sustained a witnessed, unwitnessed, alleged, or suspected head trauma following an unusual occurrence or change in resident neurological condition.
B.) The neurological check assessment in the electronic health record will be initiated to trigger the periodic checks and to document the results of the neurological checks. Unless otherwise ordered by the physician, the frequency of neurological assessments will be: every 15 minutes x 4; then every 30 minutes x 4; then every 1 hour x 4; then every 4 hours x 4; then every 8 hours x 7.
C.) Elements to be assessed: level of consciousness, mental status, ability to communicate, movement/coordination, reflexes, changes in behavior and vitals signs: (BP, pulse and respirations).

Complaint deficiency