STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. Building B. Wing	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 09404 Based on observation, clinical record review, staff interview, and review of facility documents, the facility failed for one of 25 residents in the survey sample (Resident # 109) to provide a dignified dining experience. Staff were observed feeding Resident # 109 while standing next to him. The finding were: Resident # 109 was admitted with diagnoses that included Parkinson's Disease, history of COVID-19, macular degeneration, blindness left eye, benign prostatic hyperplasia, Vitamin-D deficiency, dysphagia, chronic prostatitis, psychotic disorder with hallucinations, difficulty in walking, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly Review, with an Assessment Reference Date of 8/29/2022, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. At 12:30 p.m. on 9/7/2022, Resident # 109 was observed seated at a table in the Unit Four dining area. The resident was being fed by a Certified Nursing Assistant, later identified as CNA # 2, who was standing next to the resident as she fed him. CNA # 2 fed the resident several spoons of mashed potatoes, and cut off several bites of a sandwich and offered them to the resident using a spoon. Resident # 109 reached for a short glass of juice and was able to pull it towards him, but was unable to lift it to drink. CNA # 2 held the glass and placed a straw in the resident's mouth so he could drink. CNA # 2 then offered the resident several spoons of chocolate pudding. After offering the pudding, CNA # 2 brought Resident # 109 a cup of coffee. The resident put his right index finger through the cup handle, but was unable to hold the cup without assistance from CNA # 2. CNA # 2 then held the cup as she guided it to the resident's lips so he could take a sip of coffee. After taking a sip of coffee, CNA # 2 walked away from the resident, leaving him holding the cup only by his index finger in the cup handle. The resident was unable to hold the cup and it tipped, spilling coffee on his lap. When CNA # 2 returned to the resident, she took the cup of coffee, placed it on the table and then walked away. CNA # 2 made no effort to check the resident or clean up the spilled coffee. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After CNA # 2 left the resident's side, she was asked if Resident # 109 needed to be fed. CNA # 2 said, There has been a big change in him since he had COVID. We have to help him now. Resident # 109, who had been on 10 day isolation for COVID-19, was returned to his usual room on Unit Four on 9/6/2022. In response to a request for the facility's policy and procedure on feeding residents, the facility provided the following: Feeding the Person: Comfort: The person will eat better if not rushed. Sit to show the person that you have time for him or her. Standing communicates that you are in a hurry. Procedure: Place the chair where you can sit comfortably. Sit facing the person. (Ref. Mosby's Textbook for Long Term Care Nursing Assistants, Eighth Edition, Copyright 2020, Chapter 20, Page 299 - 302.) The findings were discussed during a meeting at 4:00 p.m. on 9/7/2022 that included the Administrator, Director of Nursing, and the survey team.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 09404 Based on complaint investigation, clinical record review, and staff interview, the facility failed for resident of 25 residents in the survey sample (Resident # 112), to notify the resident's family of a change in condition. Resident # 112 suffered a change in mental status that was not communicated to the resident's family. The findings were: Resident # 112 was admitted with diagnoses that included Multiple Sclerosis, non-pressure chronic ulcer of left lower leg, arteriosclerosis, peripheral vascular disease, restless leg syndrome, protein-calorie malnutrition, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, iron deficiency anemia, acute ischemic heart disease, hypertension, anxiety disorder, history of malignant neoplasm of bronchus and lung, absence of (part) lung, and generalized muscle weakness. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 3/11/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact with a Summary Score of 15 out of 15. Review of the Progress Notes in Resident # 112's closed Electronic Health Record revealed the following entries: 4/28/2021 - 7:56 p.m. - Skilled Note Resident has been confused today and keeps talking as if she thinks staff will harm her. She is suspicious of mediations and possible poisoning. No complaints of pain but is very difficult to redirect and get to cooperate with medication administration. Urine will be collected and will monitor closely. 4/28/2021 - 8:38 p.m. - Skilled Note .Res (Resident) has been stating to staff that staff is trying to kill her. Resident threw remote to TV and cup of full water at charge nurse. Res refuses to give staff urine for UA C&S (Urinalysis Culture and Sensitivity) .Resident yelling out loud help. Resident doesn't want staff to kill her. Res offered fluids and she threw her drink on the floor. MD will be made aware of change in mental status. Res refused vital signs. 4/29/2021 - 3:08 p.m. - Medical Note .has been having behaviors and throwing objects at staff. Told me she saw a TV show about her being a play girl which no one had business putting on TV!! 4/29/2021 - 9:34 p.m. - Skilled Note .Resident became confused and disoriented starting at around 9:00 p.m. Resident's son called expressing concern about his mother 3 times. Resident has called him and was very confused, she also called 911. Resident is stating that staff is trying to kill her, there are dead bodies in the basement and will not let us assist her to change into a gown and go to bed. Phoned Dr. (name) and we will keep an eye on her as this will be the third night in a row she has exhibited this behavior. Relayed message to Dr. (name) that son (name) would like to speak with him. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/30/2021 - 11:12 p.m. - Skilled Note Night shift aide was doing rounds and found resident lying on floor . This nurse asked resident if we could help her up off the floor, Resident stated, 'Ya'll are going to kill me anyway, so just get it over with.' . At 3:00 p.m. on 9/7/2022, the Medical Director was interviewed regarding Resident # 112 and any conversations he may have had with the resident's son. The Medical Director reviewed Resident # 112's EHR, but was unable to remember whether or not he spoke with the resident's son. There was no documentation in Resident # 112's EHR that the family was was notified of her sudden change in mental status. The findings were discussed during a meeting at 10:30 a.m. on 9/8/2022 that included the Administrator, Director of Nursing, and the survey team. COMPLAINT DEFICIENCY

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09404 Based on clinical record review and staff interview, the facility staff failed for one of 25 residents in the survey sample, to ensure the resident had a completed Preadmission Screening and Resident Review (PASARR). Resident # 109 did not have a PASARR completed at admission. The findings include: Resident # 109 was admitted with diagnoses that included Parkinson's Disease, history of COVID-19, macular degeneration, blindness left eye, benign prostatic hyperplasia, Vitamin-D deficiency, dysphagia, chronic prostatitis, psychotic disorder with hallucinations, difficulty in walking, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly Review, with an Assessment Reference Date of 8/29/2022, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. A review of Resident # 109's Electronic Health Record (EHR) revealed the resident did not have a PASARR completed at admission. Resident # 109 was admitted on [DATE]. The Discharge Planner was identified at the person responsible for obtaining the PASARR for a resident. At approximately 10:45 a.m. on 9/7/2022, the Discharge Planner was interviewed regarding a PASARR for Resident # 109. The Discharge Planner, who said she was not in that position when the resident was admitted , reviewed the resident's EHR and stated, There is no PASARR. The findings were discussed during a meeting at 4:00 p.m. on 9/7/2022 that included the Administrator, Director of Nursing, and the survey team.

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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** 27353 Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 25 residents in the survey sample. Resident #111's CCP was not reviewed and revised for adequate fall interventions and/or supervision for the prevention of falls. Findings include: Resident #111's CCP was not reviewed and revised for adequate fall interventions and/or supervision for the prevention of falls. Resident #111's diagnoses included, but were not limited to: ataxia [impaired coordination] following a non-traumatic intracerebral hemorrhage, myelodysplastic syndrome, pancytopenia, headache, anemia, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, dysphagia, mild protein calorie malnutrition, high blood pressure, atrial fibrillation, vertigo (dizziness) and fracture of right femur. The most recent full MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 11, indicating moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance from two staff for transfers, bed mobility, dressing, eating and toileting. The resident was assessed as requiring total assistance from two staff for bathing. The resident was coded as incontinent of bowel and bladder. A complaint investigation was conducted on Resident #111 on 09/06/22 through 09/08/22. An allegation within the complaint alleged that the resident had multiple falls at the facility, with the last fall resulting in a fractured hip. Resident #111's clinical records were reviewed and revealed the following. An admission assessment dated [DATE] and timed 2:50 PM documented, .on arrival: cognitively intact .Does the resident exhibit any signs of or complain .of pain? no Admission Narrative note: Resident admitted from [initial of hospital] following ICH [intracerebral hemorrhage] and CVA [stroke]. No surgical intervention pursued. Vitals are stable and c/o of headache persistently. Able to make all needs known .will evaluate. History noted for pancytopenia, HTN, afib, CVA. Family in to visit. Monitor closely . The resident's nursing progress notes were reviewed and documented the resident had a fall on 07/13/22. The resident's CCP was reviewed and the care plan included the following interventions: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.place bed in lowest position while resident is in bed Created on: 07/07/2022, ensure the resident wears shoes when ambulating Created on: 07/07/2022, place common items within reach of the resident Created on: 07/07/2022, remind the resident to use their call light to ask for assistance with ADLS Created on: 07/07/2022, reorientation to the room to assist the resident to familiarize Created on: 07/07/22, therapy referral Created on: 07/07/2022 . On 07/14/22 the CCP documented, .ACTUAL FALL: [Name of Resident #111] is at risk for injury from fall/falls. Resident had a fall. Created on: 07/14/2022, The resident will resume usual activities without further incident through the review date. Continue interventions .Created on: 07/14/2022 . The resident CCP was then updated with an intervention on 07/28/22 to include: .bed alarm to bed created on: 07/28/2022 . The resident had another fall on 07/30/22. An SBAR Summary note dated 07/30/22 documented, .The Change In Condition/s reported on this Evaluation are/were: Falls .Code Status: DNR .Recommendations: n/a .New Testing Orders .n/a .New Intervention Orders: Other - n/a . A progress note dated 7/30/2022 and timed 5:51 PM documented, .Health Status Note .Resident found sitting beside his bed, range of motion indicates no injury, assisted up off floor by 2 staff. Resident was belligerent when writer explained to him that he should always ring for assistance if he wants to get out of bed or back to bed. Stated I wanted to get up. Wife .informed. MD made aware. No other interventions and/or supervision was added for the prevention of falls. On 08/04/2022 at 7:21 PM, a progress note documented, .Fall Note .Skin tear on right shin. No other injuries noted at this time .What interventions were in place at the time of the fall? Chair alarm, What are the risk factors that could have contributed to the fall?: Confusion and gait imbalance, What new interventions were implemented in response to the fall?: Education regarding call bell usage, Was the Provider/resident and RP notified at the time of the fall?: Yes . There was no evidence of a chair alarm intervention in the physician's orders and/or on the resident's care plan (only in the note above). The resident's CCP was again reviewed. An intervention was added on 08/05/22, .Keep resident in high traffic area for safety Created on: 08/05/22 . It was documented again on 08/06/22 that the resident had another fall. The note documented, 08/06/2022 6:33 PM .Observations .BP 133/76 . bowel Status: incontinent .Pain: no .Non Pharmacological interventions provided: [blank] Pharmacological interventions provided: [blank] .Continues skilled nursing care due to intracerebral hemorrhage. A&Ox2. Takes medication whole with no issues noted. 2 person assist with ADLs. Incontinent to bowel and bladder. Skin is intact. Resident fell this evening. States he slipped out of the bed. No injuries noted. Will continue to monitor for any changes. Vitals are within normal limits. There were no new interventions and/or supervision added to the resident's CCP. On 08/07/22 the resident had another fall, this fall resulted in Resident #111 sustaining a right hip fracture. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/22 2:19 PM, a progress note documented, .health Status Note . Resident had a fall after lunch in his room. CNA [certified nursing assistant] found resident at the foot of the bed laying on his left side. Resident states he was trying to get up to go to the bathroom. After examining resident, he presented with right side hip pain that was radiating down his leg. Skin tear was noted to right elbow. Vitals were stable. Resident states he also hit his head. Notified weekend supervisor [also known as RN #2] and stated nurse was sending him to [name of hospital] ER due to possible fracture. Notified DON. Unable to get MD on the phone. Call and let emergency contact know and they were going to meet resident at the hospital. On 09/08/22 at 10:19 AM, the survey team met with the administrator, DON, and corporate nurse regarding the repeated falls Resident #111 was having and the lack of adequate supervision and/or interventions for the prevention of falls. The staff were made aware that the resident's CCP did not reflect adequate supervision and/or interventions. A fall policy was requested. The facility staff stated they would look for any additional information regarding this resident. The facility fall policy was presented and documented, .Falls Management Program .considers all patients to be at risk for falls and provides and environment as safe as practicable .a fall risk assessment will be completed upon admission, readmission, quarterly, and significant change of condition .incorporate identified interventions into the Comprehensive care plan .discuss risks and interventions .Investigate the fall, and record findings surrounding the fall .A licensed nurse will review, revise and implement interventions to the care plan based .each fall will be reviewed for causative factors utilizing the post fall assessment, device assessment and incident report .the unit manager verifies care plan revisions, patient monitoring, appropriate referrals . On 09/08/22 at approximately 11:10 AM, the DON, administrator and corporate nurse returned. The administrator stated that they had additional information to present. The DON stated that they (facility) had interventions in place, but they weren't on the resident's care plan and that they discussed the falls in their meetings. The DON presented a meeting information sheet. The information documented, .7/13/22 [name of resident] fall ? head injury resident to ED for evaluation/continue interventions .08/4/22 [name of resident] fall skin tear on right shin area resident will be place in a highly trafficked area when up to assist with fall prevention .08/06/22 [name of resident] fall none [injury] resident will be monitored for adverse effects of medications to assist with fall prevention .08/07/22 [name of resident] fall right hip pain resident sent to ER for evaluation . No information was presented for the fall on 07/30/22. The facility staff were made aware that the only new interventions that were implemented was on 07/27/22, which was the bed alarm and on 08/05/22 it was added for the resident to be put in a high traffic area. The remaining interventions were in already in place and had not been effective for Resident #111. The DON, administrator and corporate nurse were also made aware that each fall the resident had was in the resident's room, not in a high traffic area. No further information and/or documentation was presented prior to the exit conference to evidence that the facility staff reviewed and revised the CCP to include adequate supervision and/or interventions for the prevention of falls for Resident #111. This was a complaint deficiency.

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F 0689 Level of Harm - 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** 27353 Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to ensure adequate supervision and/or interventions for the prevention of falls for one of 25 residents (Resident #111), which resulted in actual harm and failed to ensure one of 25 residents (Resident #7) was safe when consuming hot liquids. Findings include: 1.) Resident #111's diagnoses included, but were not limited to: ataxia [impaired coordination] following a non-traumatic intracerebral hemorrhage, myelodysplastic syndrome, pancytopenia, headache, anemia, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, dysphagia, mild protein calorie malnutrition, high blood pressure, atrial fibrillation, vertigo [dizziness/off balance feeling] and fracture of right femur. The most recent full MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 11, indicating moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance of two staff for transfers, bed mobility, dressing, eating and toileting. The resident was assessed as requiring total assistance of two staff for bathing. The resident was coded as incontinent of bowel and bladder A complaint investigation was conducted on Resident #111 on 09/06/22 through 09/08/22. An allegation within the complaint alleged that the resident had multiple falls at the facility, with the last fall (on 08/07/22) resulting in Resident #111 sustaining a right fractured hip. Resident #111's clinical records were reviewed and revealed the following: An admission assessment dated [DATE] and timed 2:50 PM documented, .on arrival: cognitively intact .Does the resident exhibit any signs of or complain of .pain? no Admission Narrative note: Resident admitted from [name of hospital] following brain bleed and stroke. No surgical intervention pursued. Vitals are stable and c/o of headache persistently. Able to make all needs known. PT and OT will evaluate. History noted for pancytopenia, HTN, afib, CVA. Family in to visit. Monitor closely . Nursing notes were then reviewed and revealed that the resident had a fall on the following days: On 7/12/2022 at 6:27 PM, a skilled nursing note documented, .Nursing Focus: Continues skilled nursing care due to intracerebral hemorrhage. A&O (alert and oriented) x 2. Takes medication whole .2 person assist with ADLs. Incontinent to bowel and bladder No other complaints at this time . On 7/13/2022 at 6:00 PM, a nursing noted documented, .Alert Note .Patient found on the floor at 1500 [3:00 PM], fell from w/c [wheelchair], head was resting under the chair, patient indicated that he did hit head. 911 called . patient transported .Daughter .aware .VS [vital signs] stable post fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall risk assessment dated [DATE] documented that the resident was on an antihypertensive and anti-seizure medication, the resident was chair bound, incontinent and had improper body position. The assessment did not address the areas of unsafe behavior or mobility (those areas were blank). This assessment did not indicate by a score and/or other means that the resident was at risk for fall or was at high risk for falls. A fall investigation dated 07/13/22 and timed 3:00 PM was reviewed and documented that the resident was, on an anti-seizure medication, was not alert and oriented, was confused and disoriented, was restless and was in the resident's room at the time of the fall, did not call for help and that the call light was not in reach and that the resident was not wearing proper shoes and that the resident had cognitive impairment. The fall on 07/13/22 was unwitnessed and occurred in the resident's room. There were no specific details in the investigation regarding the circumstances around the fall and there were no interviews from staff. The resident's CCP (comprehensive care plan) was then reviewed and documented, .ensure the resident wears shoes when ambulating created on: 07/07/2022, place bed in lowest position while resident is in bed created on: 07/07/2022, place common items within reach of the resident created on: 07/07/2022, remind the resident to use their call light to ask for assistance with ADLS created on: 07/07/2022, reorientation to the room to assist the resident to familiarize created on: 07/07/22, therapy referral created on: 07/07/2022 . ACTUAL FALL: [Name of Resident #111] is at risk for injury from fall/falls. Resident had a fall. Created on: 07/14/2022, The resident will resume usual activities without further incident through the review date. Continue interventions on the at-risk plan Created on: 07/14/2022 . On 07/27/22 at 4:50 PM, a skilled nursing note documented, .weakness. He is alert and oriented to self, cognitive status varies .no complaints of pain .Continues to be a two assist for transfers and ADL's . The resident's physician's orders were reviewed. A bed alarm was ordered on 07/27/22. The resident's July 2022 MARs (medication administration records) were reviewed. The MARs documented the bed alarm order on the MAR and it was signed off that this intervention was in place for the resident from 07/27/22 through 07/31/22. The resident's CCP was updated and documented, .bed alarm to bed created on: 07/28/2022 . On 7/30/2022 at 5:48 PM an SBAR [situation-background-assessment-recommendation] Summary note documented, .The Change In Condition/s reported on this Evaluation are/were: Falls .Code Status: DNR . Recommendations: n/a .New Testing Orders .n/a .New Intervention Orders: Other - n/a . On 7/30/2022 at 5:51 PM a progress note documented, .Health Status Note .Resident found sitting beside his bed, range of motion indicates no injury, assisted up off floor by 2 staff. Resident was belligerent when writer explained to him that he should always ring for assistance if he wants to get out of bed or back to bed. Stated I wanted to get up. Wife .informed. MD made aware. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall on 07/30/22 was an unwitnessed fall. There was no fall investigation and/or fall risk assessment for the fall on 07/30/22. There was no information regarding the bed alarm, if it was in place and/or sounding. On 08/04/2022 at 7:21 PM, a progress note documented, .Fall Note .Skin tear on right shin. No other injuries noted at this time .What interventions were in place at the time of the fall?: Chair alarm, What are the risk factors that could have contributed to the fall?: Confusion and gait imbalance, What new interventions were implemented in response to the fall?: Education regarding call bell usage, Was the Provider/resident and RP notified at the time of the fall?: Yes . A late entry note documented, .Post Fall Documentation Late Entry: Situation: Date and time the fall occurred: 08/04/2022 4:00 PM .Background: Circumstances of the fall: unknown . Assessment (RN)/Appearance (LPN): Current status of the resident's injuries or reports of pain from the fall: no c/o pain . Recommendations: Interventions currently in place to prevent additional falls: Bed alarm and bed in lowest position .Resident's response to new interventions: no response A fall investigation dated 08/04/22 and timed 7:15 PM documented the resident was on an antihypertensive, was not alert and oriented, was confused and disoriented, was restless, the fall was in resident's room, did not call for help, call bell in reach and was wearing appropriate footwear and contributing factors was cognitive impairment. There was no specific information regarding the circumstances of the fall in this investigation or any interviews from staff. There was no information regarding the bed alarm, if it was in place and/or sounding. A fall risk assessment dated [DATE] documented that the resident was on an antihypertensive medication, tried to stand, transfer, or walk alone unsafely, propels or walks alone in unsafe places, uses assistive devices inconsistently, and that the resident was incontinent. The fall risk assessment did not address the resident's gait and balance [that section was blank] and the assessment did not provide a score or a means to quantify the resident's risk for falls. The fall on 08/04/22 was unwitnessed and occurred in the resident's room. A practitioner note dated 8/4/2022 and timed 1:00 AM documented, .Encounter . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Date of Service: 08/04/2022 Visit Type: New Evaluation .This patient is a pleasant [AGE] year-old Caucasian male currently in the skilled nursing setting following a recent hospitalization .Nursing staff reports this patient has been having episodes of increased irritability and agitation and poor safety awareness. The patient's PCP recently started this patient on Depakote 125 mg twice daily dosing for improved mood stabilizing properties. The patient is also on Remeron 15 mg nightly for insomnia and depression. The patient appears to be tolerating these medications without any adverse side effects. When the patient is seen today he is noted to be lying down in bed and is in no obvious pain or discomfort. The patient is notably only oriented to person and somewhat to place . This provider assessed the patient's pain on a 0-10 pain scale and the patient reports a pain level of 0 .The patient does report minimal anxiety and depressive symptoms due to being in the skilled nursing setting .Care Plan Recommendations: Continue the medications at current dosages as the patient is stable at this dose and dose reduction would likely cause a deterioration of the patient's psychiatric illnesses/symptoms .Monitor patient for mood changes or behaviors: i.e. agitation/aggressiveness, irritability, sleep disturbances, appetite disturbances, significant change in energy level, paranoia, hallucinations, erratic behaviors, change in LOC, mood lability, anxiety, SI/HI, or potential side effects to current psychiatric medications. If any noted please notify TeamHealth . The resident's CCP was again reviewed. An intervention was added on 08/05/22, .Keep resident in high traffic area for safety Created on: 08/05/22 . On 08/06/2022 at 6:33 PM a skilled note documented, .Observations .BP 133/76 .bowel Status: incontinent . Pain: no .Non Pharmacological interventions provided: [blank] Pharmacological interventions provided: [blank] .Continues skilled nursing care due to intracerebral hemorrhage. A&O x 2 .2 person assist with ADLs . Resident fell this evening. States he slipped out of the bed. No injuries noted. Will continue to monitor for any changes. Vitals are within normal limits. A fall investigation dated 08/06/22 and timed 6:24 PM documented that the resident was on an antihypertensive, was alert and oriented, was not confused/disoriented, was calm, the fall occurred in the resident's room, he did call for help, call light was in reach and was wearing the proper footwear and contributing factors were listed as fatigue/weakness. There was no specific information regarding the circumstances of the fall or any interviews from staff. There was no information regarding the bed alarm, if it was in place and/or sounding. The fall on 08/06/22 was unwitnessed and occurred in the resident's room. On 08/07/22 2:19 PM, a progress note documented, .health Status Note . Resident had a fall after lunch in his room. CNA [certified nursing assistant] found resident at the foot of the bed laying on his left side. Resident states he was trying to get up to go to the bathroom. After examining resident, he presented with right side hip pain that was radiating down his leg. Skin tear was noted to right elbow. Vitals were stable. Resident states he also hit his head. Notified weekend supervisor [also known as LPN #1] and stated nurse was sending him to [name of hospital] ER due to possible fracture. Notified DON. Unable to get MD on the phone. Call and let emergency contact know and they were going to meet resident at the hospital. The fall on 08/07/22 that resulted in the resident sustaining a right hip fracture was unwitnessed and occurred in the resident room. There was no investigation completed on this fall. There was no documentation regarding the resident's bed alarm, whether it was in place and/or functioning. There were no interviews from staff regarding this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #111 had the fall with injury on 08/07/22. The resident was sent to the hospital and admitted and returned to the facility on [DATE]. The resident's hospital discharge summary dated 08/10/22 documented, .primary discharge diagnosis: Acute intertrochanteric fracture of the proximal RIGHT femur, closed, presumed pathologic due to osteoporosis . confusion, presumed not new since stroke .chronic pancytopenia, likely myelodysplastic syndrome variant . He was admitted on [DATE] after a fall out of bed. He was found to have an acute right hip fracture .hospital list: fall, closed right hip fracture . On 09/07/22 at 3:50 PM, LPN#1 [also known as the weekend supervisor] was interviewed regarding Resident #111's fall on 08/07/22 [Sunday]. LPN #1 stated that she remembered the resident and that he would get up and try to self transfer and fell and broke his hip. The LPN stated he would attempt to self transfer and we (staff) continually reminded him not to get up and to use the call bell. The LPN stated that the resident was confused and that this was an unwitnessed fall. The LPN was asked if an investigation was done on this resident for this fall. The LPN stated, As far as I know we did. The LPN then looked in the resident's record and stated that she did not see an investigation for that fall for Resident #111. No further information was provided by LPN #1. On 09/08/22 at 8:48 AM, RN #3 [also known as the corporate nurse] presented information regarding Resident #111. The RN stated that they had an investigation for the resident's falls for 07/13/22, 08/04/22, and 08/06/22 and also did fall risk assessments [documented above], but they did not have an investigation for the unwitnessed falls on 07/30/22 or on 08/07/22 when the resident sustained a femur fracture. The RN stated that the resident was sent out to the hospital on those days. The fall investigations and fall risk assessments were reviewed and RN #3 was made aware that the fall risk assessment did not score the resident for fall risks. The RN stated that she was aware of that and that they (facility) were working on a scoring system to better assess fall risk residents. The RN was made aware that the fall investigations were vague and did not provide any real details surrounding the resident's falls and did not have any staff interviews and/or statements that may provide additional information surrounding the falls. The RN was made aware of the serious concerns regarding the resident repeat falls and the resident's fall on 08/07/22, which resulted in harm. On 09/08/22 09:06 AM, LPN (Licensed Practical Nurse) #7 was interviewed regarding Resident #111. LPN #7 stated that the resident used to be in room [ROOM NUMBER] and that she normally worked that area and worked with that resident. The LPN stated, Since the resident first came to us, he was ., I wouldn't use the word non-compliant, but he was hard to get to do stuff, he didn't want to eat or drink, he'd raise the bed up and down and he was a big fall risk. We had to keep encouraging him to use the call bell, he would keep attempting to get up. We had an extended bed for him [he was tall] and he had a bed alarm .I think he had a bed alarm, he didn't have a chair alarm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LPN #7 further stated, When he came back from the hospital he was on hospice and they [hospice] ordered fall mats and had them delivered and we put them down, I remember because they were pink. I think he was in the chair some and we'd bring him out in the hall, but that was rare. He was a big sleeper and spent a lot of time in his room and in bed. For the most part while I was here he wanted to stay in the bed and sleep. The day he fell the last time [08/07/22], I did not hear an alarm that day, I'm not sure if it was on or not, but I had heard that in the past and remembered the sound it was really loud and annoying, but I didn't hear it that day. One of the girls working was a TNA (temp nurse aid) she is no longer working here and a CNA I don't recall her name. He (Resident #111) was my patient and I was doing med pass when that happened. Of course, it was an unwitnessed fall and from what I understand the CNA took the [lunch] tray in and left and then went to get his roommates tray and came back and he (Resident #111) was on the floor. He was not a big drinker and didn't eat much and we would have to encourage him. LPN #7 was asked who updates the care plans. The LPN stated that she thought it would be the unit managers or MDS, but she had not done that. The LPN stated that the Unit Manager was LPN #1 when the resident's last fall occurred, I believe it was a Saturday or Sunday and LPN #1 was the supervisor. LPN #7 stated that she went to the resident's room immediately, checked the resident out, checked his vitals, and stated, 'for me to even touch his leg he was screaming in pain.' LPN #7 stated that she went and got LPN #1 and they both went to the resident and both agreed that he needed to be sent out. LPN #7 stated that the resident's wife was there just before the resident fell and stated that his wife did tell the TNA that he had attempted to get up before she left. LPN #7 stated that she did not hear the resident's wife say that, but that is what the TNA told her and reported to her after the fall occurred. LPN #7 stated that 911 was called and when EMS [emergency medical services] got here, he [resident] was in so much pain that they had to medicate him and stated that she believed they gave him IV [intravenous] fentanyl to get him on the gurney because he was in so much pain. LPN #7 stated, He never did use the call bell to my knowledge. The LPN stated that she worked with him frequently and the resident seemed to decline pretty fast and the resident was typically quite most of the time. LPN #7 stated that she did not recall the resident being combative with care or anything like that. LPN #7 stated that was the first time he fell on her shift. LPN #7 stated, I had a feeling that was going to happen with him anyways. The facility's fall policy was presented, Falls Management Program .considers all patients to be at risk for falls and provides and environment as safe as practicable .a fall risk assessment will be completed upon admission, readmission, quarterly, and significant change of condition .incorporate identified interventions into the Comprehensive care plan .discuss risks and interventions .do not move or reposition until a licensed nurse has completed a physical and mental assessment .assess, intervene, and promptly provide the necessary interventions for any patient experiencing a fall .notify physician, responsible party and EMS .post fall include neurological assessment if the fall was unwitnessed .complete post fall assessment to determine, to the extent possible the cause of a patient fall .Investigate the fall, and record findings surrounding the fall . A licensed nurse will review, revise and implement interventions to the care plan based on: post fall assessment findings, review device assessment, review of fall risk assessment .unit manager will review the incident report and any post fall follow up .each fall will be reviewed for causative factors utilizing the post fall assessment, device assessment and incident report .the unit manager verifies care plan revisions, patient monitoring, appropriate referrals . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/08/22 at 10:19 AM, the survey team met with the administrator, DON, and corporate nurse. The staff were made aware of serious concerns regarding repeated falls for this resident and specifically the fall 08/07/2, which resulted in fractured hip. The facility staff were made aware of the concerns regarding the lack of supervision and/or interventions for the prevention of falls for this resident, who had been identified as known as being at risk. The facility staff stated that they would look for any additional information. On 09/08/22 at approximately 11:10 AM, the DON, administrator and corporate nurse returned and stated that they had additional information. The DON stated that the discharge summary documented that the resident's fracture was pathological and that it could not be proven that this fall (the fall from the bed on 08/07/22) is what caused the resident's fracture. The DON was made aware that the discharge summary documented, that the resident had an Acute intertrochanteric fracture of the proximal RIGHT femur . presumed pathologic due to osteoporosis. The discharge summary also that the resident had a fall out of bed and was found to have an acute right hip fracture and was then admitted to the hospital. The DON was also made aware according to Resident #111's clinical records, Resident #111 did not have a previous diagnosis of osteoporosis or a current diagnosis of osteoporosis. The facility staff were made aware that through the complaint investigation and interviews, the resident was in severe pain after the fall that resulted in the hip fracture and that, according to interviews the resident was screaming out in pain when the nursing staff attempted to touch and assess the resident's leg. It was also reported that the EMS had to medicate the resident to be able to get the resident on the gurney due to the severity of the pain he was experiencing. The DON, administrator and corporate nurse were also made aware that the resident's care plan was not updated with new fall interventions and/or supervision and that there was no investigation completed by the facility of this unwitnessed fall. The DON stated that they had interventions in place, but they weren't on the resident's care plan and they (staff) discussed the falls in their meetings and presented documentation to the survey team. The information documented, .7/13/22 [name of resident] fall ? head injury resident to ED for evaluation/continue interventions.[no new interventions added] 08/4/22 [name of resident] fall skin tear on right shin area resident will be place in a highly trafficked area when up to assist with fall prevention [this intervention was added to the care plan] .08/06/22 [name of resident] fall none [injury] resident will be monitored for adverse effects of medications to assist with fall prevention [this intervention was added to the care plan on 08/08/22 after the fall with injury] .08/07/22 [name of resident] fall right hip pain resident sent to ER for evaluation . No information was presented for the fall on 07/30/22. The facility staff were made aware that these interventions were the same interventions already in place and that the only new intervention for actual fall prevention was putting the resident in a high traffic area which was implemented on 08/05/22. The facility staff were also made aware that the all of the resident's falls occurred in the resident's room (not in a high traffic area) and all of the resident's falls were in unwitnessed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	No further information and/or documentation was presented prior to the exit conference on 09/08/22 at 11:45 AM to evidence that adequate supervision and/or interventions were implemented for Resident #111 for the prevention of falls, which subsequently resulted in injury. Resident #111 had a total of five falls between 07/06/22 and 08/07/22. The resident sustained a right hip fracture as result of the last fall on 08/07/22 (the resident's last fall). This is a complaint deficiency. 29123 2. Resident #71 was admitted to the facility with the following diagnoses, including but not limited to: Left femur fracture, dementia, protein-calorie malnutrition, and hypertension. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/04/2022 assessed Resident #71 as having problems with both long and short term memory, as well as severely impaired with daily decision making skills. On 09/06/2022 at approximately 12:30 p.m., the lunch time meal was observed, Resident #71 was sitting up in her wheelchair, her lunch tray was on a table in front of her. She was attempting to feed herself. Her napkin was crumpled in the middle of her plate, her cold drink was spilled onto the tray, the plate, the table, her clothes, and the floor. She was asked if she needed any help. She stated, I spilled it. A nurse in the hallway was asked to come to the room. She spoke with Resident #71 and went to get her another tray and drink. On 09/07/2022 at approximately 8:30 a.m., Resident #71 was observed sitting in her bed. Her breakfast was on the bedside table in front of her. The front of her gown was wet. She had her coffee cup in her hand and was attempting to get it to her mouth. The coffee spilled down the front of her gown. CNA (certified nursing assistant) #1 was in the adjacent room. She was called to Resident #71's bedside and told about the spilled coffee. She removed the cup from Resident #71's hand. She was asked if the coffee cup was hot to touch, she nodded her head. She was asked if Resident #71 was hurt. She left the room and spoke with RN (registered nurse) #1. RN #1 came to the room. She and CNA #1 removed Resident #71's gown. Her chest was not red and she denied pain. The MDS (ARD 08/04/2022) was reviewed at approximately 8:45 a.m. Under section G, Functional Status, Resident #71 was assessed as a 1/2 for eating, meaning Supervision-oversight, encouragement, or cueing/One person physical assist. The care plan was reviewed. The Focus area ADL (activities of daily living) . contained the following intervention regarding eating: (Resident name) is able to feed herself after set up. she needs encouragement to complete meals. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was interviewed at approximately 9:00 a.m. regarding Resident #71. CNA #1 stated that Resident #71's dementia had gotten worse over the last couple of weeks. She stated, She's been spilling more, her hand motions are more jerky. She was asked if the facility had cups with lids. She stated, The lids we have right now don't really fit the cups. She was asked if the facility had cups with spouts to prevent spills She spoke with LPN (licensed practical nurse) #5 who stated, We have those cups, we'll get her one to use (Name of Resident #71) just came out of isolation for COVID, before that she was up and around the unit. She hasn't gotten her strength back .she also needs to be up in the chair when she's eating not sitting up in the bed, that will help .I will update the care plan. During the lunchtime meal on 09/07/2022 Resident #71 was observed with a plastic cup, with handles on each side, and a spout on the lid. There were no spills observed. The above information was discussed during an end of the day meeting on 09/07/2022. The administrative team was asked if there was an assessment done regarding hot liquid safety. The corporate nurse consultant stated, The company has one, but I don't know if it has been implemented here. I will look. On 09/08/2022 a hot liquid assessment for Resident #71 was presented. It was dated 06/14/2022. The resident was not assessed as being at risk for drinking hot liquids. The corporate nurse consultant was asked if there was a policy on when the hot liquid assessment should be done. During a meeting on 09/08/2022 at approximately 10:30 a.m., the corporate nurse consultant stated that there was no policy regarding the hot liquid assessment, but it should be done quarterly, annually, and if there was a change. No further information was obtained prior to the exit conference on 09/08/2022.