STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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	E 000		
	An unannounced Emergency Preparedness survey was conducted 05/14/19 through 05/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid Standard Survey and State Licensure survey were conducted 05/14/19 through 05/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 4 closed record reviews. Six complaints were investigated during this survey.			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625		6/20/19

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

Electronically Signed — 06/10/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 625	Continued From page 1 plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide written notice to the Resident or the Resident's responsible party of the facility's bed hold upon transfer for 2 of 27 Residents. Residents #104 and #105. The findings included: 1. For Resident #104, the facility staff failed to offer the Resident and/or their responsible party a bed hold when the Resident was transferred to an acute care hospital. The clinical record review revealed that Resident #104 had been admitted to the facility 01/17/19 and had been readmitted on 02/08/19. Diagnoses included, but were not limited to, cerebral infarction, flaccid hemiplegia, dysphagia, congestive heart failure, anoxic brain damage, diabetes, and seizures.	F 625	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F625 1. Resident #104 and 105 charts were reviewed at the time of survey. 2. Residents that have been transferred out to the acute care hospital in the last 30 days were audited to assure that the bed hold policy was reviewed with the resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 625	Continued From page 2 Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/24/19 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Resident #104 had been transferred and admitted to an acute care hospital on 01/28/19 and again on 02/11/19. The facility was unable to provide any evidence that a bed hold had been offered upon transfer/admit. The administrative staff were notified of the above issue during a meeting with the survey team on 05/16/19 at 3:57 p.m. Prior to the exit conference, the administrator provided the surveyor with a typed document titled, "Patient Transfer Correction Plan." This document did not meet the requirements of a plan of correction. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #105, the facility staff failed to offer the Resident and/or their responsible party a bed hold when the Resident was transferred to an acute care hospital. The clinical record review revealed that Resident #105 had been admitted to the facility 05/14/18 and had been readmitted on 11/23/18. Diagnoses included, but were not limited to, malignant neoplasm of kidney and thyroid gland, chronic pain, dysphagia metabolic encephalopathy,	F 625	and sent with them on the transfer. 3. Licensed staff will be educated on the Bed Hold policy and information that must accompany the resident to the hospital at the time of transfer by DON/Designee by 6/18/19. 4. DON/ Designee will audit records for residents transferred to the hospital at least 5 times weekly for 4 weeks then monthly times 2 months to assure that the bed hold policy was sent with the resident to hospital. 5. Audits will be reviewed at the QAPI committee and any non- compliance will be reported for tracking and trending and progressive disciplinary action as needed. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 625	Continued From page 3 chronic kidney disease, dementia, and adult failure to thrive Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/30/18 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Resident #105 had been transferred and admitted to an acute care hospital on 12/28/18. The facility was unable to provide any evidence that a bed hold had been offered upon transfer/admit. The administrative staff were notified of the above issue during a meeting with the survey team on 05/16/19 at 3:57 p.m. Prior to the exit conference, the administrator provided the surveyor with a typed document titled, "Patient Transfer Correction Plan." This document did not meet the requirements of a plan of correction. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 625		
F 658 SS=D	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:	F 658		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 658	Continued From page 4 Based on staff interview, clinical record review, facility document review and in the course of a complaint survey the facility staff failed to follow professional standards of practice for the administration of medications for 1 of 27 Residents, Resident #55. The findings included: For Resident #55 the facility staff signed the eMAR (electronic medication administration record) when the medication, Bactrim, was not administered and administered Bactrim when the Resident has it listed as an allergy. Resident #55 was admitted to the facility on 10/17/16 and readmitted on 08/02/18. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, multidrug-resistant organism, diabetes mellitus, hyperlipidemia, dementia, anxiety, depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/01/19 coded the Resident as 13 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #55's clinical record was reviewed on 05/15/19. It contained a physician's order summary for the months of December 2018 through February 2019, which read in part "Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth every 12 hours for MRSA (methicillin resistant staphylococcus aureus) for 7 days". This order was dated 01/30/19 with a start date of 01/30/19 and an end date of 02/06/19.	F 658	F658 1. Resident 55 chart was reviewed, and MD was made aware we did not give the Bactrim as ordered due to allergies. 2. Audit was done of current residents to assure that allergies are flagged and appropriate and no one was receiving medications they were allergic to. 3. DON/Designee educated licensed staff on professional standards for documentation of medications and what to do if resident is allergic to medications by 6/18/19 4. DON/ Designee will monitor new orders at least 5 time weekly for 4 weeks and they monthly to assure that medications are given as ordered and no allergies noted with new orders. 5. Audits will be reviewed at the QAPI committee and any non-compliance will be reported for tracking and trending and progressive disciplinary action. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 658	Continued From page 5	F 658		

Resident #55's eMAR's (electronic medication administration record) for the months of January and February 2019 were reviewed. The eMAR contained an entry, which read in part "Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth every 12 hours for MRSA for 7 days". This entry was initialed as having been administered at 2100 (9 pm) on 01/30/19-02/05/19, and at 0900 on 02/02/19-02/03/19 and 02/05/19-02/06/19. The entry was coded as "5" on 01/31/19 at 0900, which is the equivalent of "hold/see progress notes". The entry was coded as "9" on 02/01/19 and 02/04/19 at 0900. Chart code "9" is equivalent to "other/see progress notes.

Resident #55's progress notes were reviewed and contained nurse's progress notes, which read in part "01/31/19 12:35 Bactrim DS Tablet 800-160 MG Give 1 tablet by mouth every 12 hours for MRSA for 7 days", "02/01/19 09:47 Bactrim DS Tablet 800-160 MG Give 1 tablet by mouth every 12 hours for MRSA for 7 days pt (patient) is allergic to Bactrim. MD notified", and "02/04/19 13:34 Bactrim DS Tablet 800-160 MG Give 1 tablet by mouth every 12 hours for MRSA for 7 days allergic".

Surveyor spoke with pharmacist #1 on 05/16/19 at approximately 0855 regarding Resident #55's Bactrim. Pharmacist #1 stated that they have no record of ever having dispensed the Bactrim for Resident #55.

Surveyor spoke with pharmacist #2 on 05/16/19 at approximately 0930. Pharmacist #2 stated the pharmacy had never received an order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 658	Continued From page 6 Bactrim for Resident #55, and had no record of the Bactrim having been sent to the facility nor did they have any record of it having been taken from the facility stat box. Surveyor spoke with the RNC (regional nurse consultant) on 05/1619 at approximately 0945. RNC stated that she had spoken with the pharmacy, and they had informed her that there was no record of the Bactrim being sent for Resident #55. RNC stated that she did not know where the Bactrim was obtained in order to be administered to Resident #55. Surveyor spoke with LPN (licensed practical nurse) #1 on 05/16/19 at approximately 1455 regarding Resident #55. LPN #1 stated that the previous nurse informed her that Resident was allergic to Bactrim; therefore, she did not administer it. Surveyor asked LPN #1 if the Bactrim was in the medication cart, and she stated that she could not recall. Surveyor spoke with LPN #2 on 05/16/19 at approximately 1500. LPN #2 stated that had not worked with Resident #55. Surveyor spoke with LPN #3 on 05/16/19 at approximately 1515. LPN #3 stated that she had pulled the Bactrim from the stat box to administer to Resident #55. LPN #3 also stated that she had asked the Resident if he was allergic to the Bactrim and if he was having any problems from taking it, and Resident stated that he was not having any reaction to the Bactrim. Surveyor spoke with RN (registered nurse) #1 on 05/15/19 at approximately 1525. RN #1 stated that she did not really recall if she gave the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 658	Continued From page 7 Resident's Bactrim. Surveyor asked RN #1 if the Bactrim was in the medication cart and RN #1 stated that she could not recall. Surveyor asked RN #1 to confirm her initials on the eMAR for the dates she had initialed, and RN #1 confirmed her initials, and stated, "I probably just signed it and didn't give it if it wasn't there". Surveyor requested the facility's standard of practice for medication administration and was provided with a facility policy entitled "General Dose Preparation and Medication Administration", which read in part "4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct Resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule. 4.1.4 Check for allergies to the medication...6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given...) on appropriate forms". The concern of signing the eMAR when a medication was not given and giving a medication that the Resident was allergic to was discussed with the administrative team during a meeting on 05/16/19 at approximately 1600. No further information was provided prior to exit. This is a complaint deficiency.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 8 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to follow physician's orders for 5 of 27 Residents, Resident #55, Resident #1, Resident #64, Resident #303, and Resident #152. The findings included: 1. For Resident #55 the facility staff failed to administer physician ordered treatments. Resident #55 was admitted to the facility on 10/17/16 and readmitted on 08/02/18. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, multidrug-resistant organism, diabetes mellitus, hyperlipidemia, dementia, anxiety, depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/01/19 coded the Resident as 13 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #55's CCP (comprehensive care plan) was reviewed and contained care plans for "Resident has Peripheral Vascular Disease" and "The Resident has a venous/stasis ulcer of the	F 684	F684 1. Resident # 55, 1, 64, 303 and 153 MD was notified that medications and treatments were not completed as ordered. 2. Current residents□ charts were reviewed for the last 30 days to assure that orders were completed as ordered. 3. DON/ Designee educated licensed staff on proper documentation of medications and treatment administration and when to notify the MS+D when cannot complete orders by 6/18/19 4. DON/ Designee will monitor missed administration report at least 5 times per week for 4 weeks then monthly times 2 to assure that medications and treatments were administered as ordered. 5. Any non-compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 9 ankle r/t PVD (peripheral vascular disease)". Interventions for these care plans include "compression stockings as ordered, meds as ordered, TED hose as ordered to right leg, tubi-grip to the left leg, apply dressing as ordered, and elevate legs as much as possible". Resident #55's physician order summary was reviewed and contained the following orders: "elevate BLE (bilateral lower extremities) while in wheelchair and in bed-order date 01/24/19", "keep dressing clean, dry, and intact every shift-order date 04/18/19, end date-05/07/19", "cleanse wounds to the left med ankle with soap and water, apply Aquacel Ag and secure with loose Kerlix dressing every evening shift every 3 days for wound-order date 05/06/19, end date-05/14/19", "cleanse right foot with soap and water, apply Aquacel Ag and secure with loose kerlix dressing every evening shift every 3 days-order date 05/06/19, end date 05/13/19", "Patient needs to keep his feet level. Patient not to stay in wheelchair all day. Needs to be in bed with legs level. Only up in wheelchair with meals every evening shift-order date 05/06/19", "Place gauze between toes on right toe every evening shift-order date 05/06/19, end date-05/13/19", "May apply antifungal lotion to bilateral extremities. Do not place between toes, must stay dry every day and evening shift-order date 05/06/19", and "May ambulate as tolerated every shift-start date 04/11/19, end date-05/14/19". Resident #55's eTAR for February was reviewed and contained an entry, which read in part "Tubi grips on in the AM: Off in the PM every day evening shift-order date 01/23/2019". This entry had not been initialed as completed on 02/03/19.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 10 Resident #55's eTAR's for the months of April and May 2019 were reviewed. The eTAR for April and May contained an entry, which read in part "Elevate BLE while in wheelchair". This entry had not been initialed as completed on 04/21/19 or 04/29/19 for days, 05/05/19, 05/08/19, 05/09/19, 05/13/19 or 05/14/19 on evenings, and 05/10/19 on nights. The eTAR for April and May contained and entry, which read in part "Keep dressing dry and intact every shift". This entry had not been initialed as completed on 04/21/19 or 04/29/19 on days, and 05/05/19 on evenings. The eTAR for April and May contained an entry, which read in part "May ambulate as tolerated". This entry had not been initialed as completed on 04/21/19 or 04/29/19 on days, 05/05/19, 05/08/19, 05/09/19 or 05/13/19 on evenings and 05/10/19 on nights. The eTAR for May contained an entry, which read in part "Cleanse open wounds to the left med ankle with soap and water, apply Aquacel Ag and secure with loose Kerlix dressing every evening shift every 3 days for wound". This entry had not been initialed as completed on 05/09/19. The eTAR for May contained in entry, which read in part "cleanse right foot with soap and water, apply Aquacel Ag and secure with loose kerlix dressing every evening shift every 3 days". This entry had not been initialed as completed on 05/09/19. The eTAR for May contained an entry, which read in part "Patient needs to keep his feet level. Patient not to stay in wheelchair all day. Needs to be in bed with legs level. Only up in wheelchair with meals every evening shift". This entry was not initialed as completed on 05/08/19, 05/09/19. 05/13/19 or 05/14/19. The eTAR for May contained an entry, which read in part "Place gauze between toes on right toe every evening shift". This entry had not been initialed a completed on 05/08/19 or 05/09/19. The eTAR for	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 11 May contained an entry, which read in part "May apply antifungal lotion to bilateral extremities. Do not place between toes, must stay dry every day and evening shift". This entry had not been initialed as completed on 05/08/19, 05/09/19, 05/13/19 or 05/14/19 on evenings. The concern of not administering physician ordered treatments was discussed with the administrative team during a meeting on 05/16/19 at approximately 1600. No further information was provided prior to exit. This is a complaint deficiency. 2. For Resident #1 the facility staff failed to administer a physician ordered medication. Resident #1 was admitted to the facility on 04/25/19 and readmitted on 05/01/19. Diagnoses included but not limited to lung cancer, congestive heart failure, hypertension, gastroesophageal reflux disease, benign prostatic hyperplasia, end stage renal disease, hypothyroidism, depression, chronic obstructive pulmonary disease, respiratory failure, dysphagia, insomnia and constipation. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/08/19 coded the Resident as 11 out of 15 in section C, cognitive patterns. This is an admission MDS. Resident #1's clinical record was reviewed on 05/16/19. It contained a signed physician's order summary, which read in part "Prednisone tablet 10 mg. Give 40 mg by mouth one time a day for	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 684	Continued From page 12 COPD (chronic obstructive pulmonary disease) for 7 days". Resident #1's eMAR (electronic medication administration record) for the month of May 2019 was reviewed, and contained an entry, which read in part "Prednisone tablet 10 mg. Give 40 mg by mouth one time a day for COPD for 7 days". This entry was coded "5" on 05/02/19 and 05/03/19. Chart code "5" is equivalent to "Hold/see progress notes". Resident #1's progress notes were reviewed and contained progress notes, which read in part "05/02/19 09:45 prednisone tablet 10 mg. Give 40 mg by mouth one time a day for COPD for 7 days" and "05/03/19 13:31 Prednisone tablet 10 mg. Give 40 mg by mouth one time a day for COPD for 7 days". The nurse's progress noted did not specify the reason the medication was held. The concern on not administering the physician prescribed medication was discussed with the administrative team during a meeting on 05/16/19 at approximately 1600. No further information was provided prior to exit. The findings included 3. The facility staff failed to follow physician's orders regarding the administration of Trazodone for Resident # 64. Documentation from the record reflected a discrepancy for the Trazodone where one order reflected 150 mg. of Trazodone and another order for 100 mg. of Trazodone. Resident # 64 was a 62-year-old-female who was admitted to the facility on 10/4/18. Diagnoses	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 13 included but were not limited to; major depressive disorder, insomnia, type 2 diabetes mellitus, and anxiety. The clinical record for Resident # 64 was reviewed on 5/16/19 at 10:00 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/30/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 64 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 64 was cognitively intact. The current plan of care for Resident # 64 was reviewed and revised on 4/29/19. The facility staff documented a focus area for Resident # 64 as, "The resident uses psychotropic medications r/t (related to) insomnia, depression, anxiety." Interventions included but were not limited to; "Monitor for side effects and effectiveness." Resident # 64 had current orders that included but were not limited to; "Trazodone HCl tablet 150 mg (milligram) give 0.5 (1/2) tablet by mouth at bedtime for depression," which was initiated by the physician on 12/21/18. On 5/16/19 at 12:22 pm, the surveyor observed a pharmacy consultation report in Resident # 64's clinical record dated 12/13/18. The pharmacy consultation report contained documentation that included but was not limited to; ..." Comment Resident # 64 has received trazodone 100 mg at bedtime for insomnia since 10/18. Recommendation	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 14 Please consider a GDR (gradual dose reduction) to trazodone 75 mg at bedtime for insomnia. Physician Response I decline the recommendation(s) above because the GDR is clinically contraindicated for this individual as indicated below. 1. Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair the individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below, 2. Please provide CMS (Centers for Medicare & Medicaid Services) required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual: continues to have difficulty with insomnia (handwritten documentation)." ... The surveyor observed that this order was given on 1/11/19 by the psychiatric mental health nurse practitioner, and approved on 1/22/19 by the facility nurse practitioner. On 5/16/19 at 12:46 pm, the surveyor and the director of nursing reviewed the pharmacy consultation sheet that was approved by the facility nurse practitioner on 1/22/19 and the May 2019 medication administration record for Resident # 64. The director of nursing agreed that the facility staff did not carry out the orders as instructed by the nurse practitioner on 1/22/19. On 5/16/19 at 3:56 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 5/16/19.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 15 4. The facility staff failed to follow physician's orders for TED hose (compression stockings) for Resident # 303. Resident # 303 was an 89-year-old-male who was admitted to the facility on 5/6/19. Diagnoses included but were not limited to; edema, hypertension, major depressive disorder, and atrial fibrillation. The clinical record for Resident # 303 was reviewed on 5/15/19 at 11:43 am. The most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 5/13/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 303 had a BIMS (brief interview for mental status) score of 11 out of 15, which indicated that Resident # 303's cognitive status was moderately impaired. The plan of care for Resident # 303 had not been completed at the time of the survey. Resident # 303 had orders that included but were not limited to; "TED hose on in am and off in pm every morning and at bedtime," which was initiated by the physician on 5/7/19. On 5/14/19 at 6:16 pm, during initial tour of the facility, the surveyor observed Resident # 303 in his room siting in his wheelchair. The surveyor observed that both of Resident # 303's lower extremities were wrapped in Kerlix. The surveyor did not observe Resident # 303 wearing TED hose at that time. On 5/15/19 at 8:54 am, the surveyor observed	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 16 Resident # 303 sitting in his room in his wheelchair. The surveyor observed that both of Resident # 303's lower extremities were wrapped in Kerlix. The surveyor observed that Resident # 303 was not wearing TED hose. On 5/15/19 at 9:59 am, the surveyor reviewed the May 2019 treatment administration record for Resident # 303. The surveyor observed documentation on Resident # 303's May 2019 treatment administration record that reflected that TED hose were in place during the evening shift on 5/14/19, and during day shift on 5/15/19 when the surveyor observed that TED hose had not been applied on Resident # 303. On 5/15/19 at 11:03 am, the surveyor observed Resident # 303 in the hallway as he was pushed back into his room by therapy staff. The surveyor observed that Resident # 303 was not wearing TED hose. On 5/16/19 at 11:15 am, the surveyor observed Resident # 303 in his room lying in bed. The surveyor observed that Resident # 303 was not wearing TED hose. On 5/16/19 at 11:30 am, the surveyor reviewed the May 2019 treatment administration record for Resident # 303. The surveyor observed documentation that reflected that TED hose were in place during the day shift on 5/16/19, when the surveyor observed that TED hose had not been applied on Resident # 303. On 5/16/19 at 11:59 am, the surveyor and the director of nursing went to Resident # 303's room and observed that Resident # 303 was lying in bed. The surveyor and the director of nursing	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 684	Continued From page 17 observed Resident # 303's lower extremities and the director of nursing agreed that Resident # 303 was not wearing TED hose. The surveyor and the director of nursing reviewed the May 2019 treatment administration record for Resident # 303 and the director of nursing agreed that there was documentation on Resident # 303's treatment administration record for day shift on 5/16/19 that reflected that TED hose had been applied to Resident # 303, but the surveyor and director of nursing observed that TED hose were not in place. On 5/16/19 at 3:56 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/16/19. 5. For Resident #153, facility staff failed to administer the antibiotic Levaquin as ordered. Resident #153 was admitted to the facility on 5/13/19. Diagnoses included bradycardia, hyponatremia, complicated urinary tract infection (UTI), general weakness, and hypothyroid. At the time of the survey, the initial comprehensive minimum data set assessment had not been completed. Clinical record review revealed hospital discharge orders included two doses of Levaquin 500 milligrams to complete the course of antibiotics started in the hospital. A Facility physician admission orders included Levaquin Tablet 500 mg (Levofloxacin) Give 1 tablet by mouth one time a day for infection for 2 administrations Order Date-5/13/19 1738 -D/C Date-5/15/19 0822. The medication administration record (MAR) indicated one dose	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 684	Continued From page 18 was administered at 9 AM on 5/14/19. A second order was written for Levaquin Tablet 500 mg (Levofloxacin) Give 1 tablet by mouth one time a day for UTI for 1 administration Order Date-5/15/19 0822. The MAR for 5/15/19 was marked 9 (other/see progress note). A progress note dated 5/15/19 at 1450 documented on order. A third order for Levaquin Tablet 500 mg (Levofloxacin) Give 1 tablet by mouth one time only for UTI until 5/16/19 2359. The MAR indicated it was administered at 947. The surveyor reported the concern to the administrator and director of nursing during a summary meeting on 5/15/19 at approximately 3 PM. On 5/16/19 at 2:30 PM, the surveyor spoke with the resident's medication nurse from 5/15/19. The medication nurse said that the Levaquin was not in the unit 1 stat box. The nurse stated she had not realized the unit 2 stat box had different medications, including Levaquin. If she had known that, she would have gotten it there for the 5/15 dose.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 690	Continued From page 19 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to provide services necessary to prevent urinary tract infections for 1 of 27 Residents in the survey sample, Resident # 306. The findings included The facility staff failed to ensure that the Foley catheter for Resident # 306 was anchored. Resident # 306 was an 84-year-old-female who was admitted to the facility on 5/4/19. Diagnoses	F 690	F690 1. Resident # 306 foley catheter was anchored at the time of survey 2. Current residents with foley catheters were audited to assure that anchors are in place as ordered. 3. DON/Designee educated staff on the importance of anchoring the foley catheters for comfort and prevent UTI by 6/18/19 4. New admission will be audited at least 5 times per week for 4 week and they monthly times 2 to assure that residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 690	Continued From page 20 included but were not limited to; urinary retention, anxiety, urinary tract infection, and insomnia. The clinical record for Resident # 306 was reviewed on 5/15/19 at 11:53 am. The most recent MDS (minimum data set) assessment for Resident # 306 was an admission assessment with an ARD (assessment reference date) of 5/11/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 306 had a BIMS (brief interview for mental status) score of 9 out of 15, which indicated that Resident # 306's cognitive status was moderately impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 306 had an indwelling catheter. The current plan of care for Resident # 306 was reviewed and revised on 5/15/19. The facility staff documented a focus area for Resident # 306 as, "The resident has indwelling Foley catheter 14Fr (French) 10 cc (cubic centimeters)." Interventions included but were not limited to, "The resident has an indwelling Foley catheter 14 FR 10 CC. Position catheter bag and tubing below the level of the bladder." Resident # 306 had current orders that included but was not limited to, "Anchor Foley catheter Q (every) shift," which was initiated by the physician on 5/14/19. On 5/16/19 at 7:35 am, the surveyor entered Resident # 306's room to conduct a Resident interview. The surveyor observed Resident # 306 sitting in her wheelchair. Resident # 306 was wearing a pink robe and had her legs positioned	F 690	admitted with foley catheters has anchor applied and order in place 5. Any non- compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 690	Continued From page 21 in way that the surveyor observed that Resident # 306's catheter was not anchored. On 5/16/19 at 7:46 am, interviewed Resident # 306 about her Foley catheter. Resident # 306 stated she was having a hard time urinating and that was the reason she had the catheter. The surveyor asked Resident # 306 if she would allow her to observe her Foley catheter. Resident # 306 lifted her robe and showed the surveyor her Foley catheter. The surveyor observed that Resident # 306's catheter was not anchored. The surveyor asked Resident # 306 if her catheter got caught on things that caused her catheter to pull and become uncomfortable. Resident # 306 responded, "At times it does." On 5/16/19 at 9:30 am, the surveyor reviewed the treatment administration record for Resident # 306. The surveyor observed documentation that reflected that the Foley had been monitored on day shift on 5/16/19 and that an anchor was in place. On 5/16/19 at 11:33 am, the surveyor observed Resident # 306 in her room while CNA # 1 (certified nursing assistant) was providing assistance. The surveyor observed that the Foley catheter for Resident # 306 was not anchored. The surveyor spoke with the CNA # 1 after she exited Resident # 306's room. The surveyor asked CNA # 1 if Resident # 306's catheter should be anchored. CNA # 1 stated, "Yes it was yesterday." "I am going to go and tell the nurse." On 5/16/19 11:38 am, the surveyor approached LPN # 1 (licensed practical nurse) and asked if she was responsible for the care of Resident # 306 on 5/16/19. LPN # 1 stated that she was	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 690	Continued From page 22 responsible for the care of Resident # 306 on 5/16/19. The surveyor and LPN # 1 reviewed the May 2019 treatment administration record for Resident # 306. While the surveyor and LPN # 1 was reviewing the treatment administration record for Resident # 306, the surveyor observed that there was documentation that reflected that Resident # 306's Foley catheter had been monitored and that an anchor was in place. LPN # 1 stated, "I have to go check that." The surveyor asked LPN # 1 if the documentation on Resident # 306's treatment administration record reflected that Resident # 306's Foley catheter had been monitored and that an anchor was in place. LPN # 1 stated, "Yes." The surveyor informed LPN # 1 that she observed Resident # 306's Foley catheter, and that the catheter was not anchored. LPN # 1 stated, "It was on her this morning." The surveyor asked LPN # 1 what time she saw the anchor on Resident # 306. LPN # 1 replied, "Around 7:30 or 8:00." The surveyor informed LPN # 1 of her observations of Resident # 306's unanchored catheter at 7:35 am, 7:46 am, and 11:33 am on 5/16/19. LPN # 1 responded, "I will fix it." On 5/16/19 at 3:56 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 5/16/19.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 698	Continued From page 23 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to communicate with the dialysis center for 2 of 27 Residents, Residents #16 and #82. The findings included: 1. For Resident #16, the facility staff failed to communicate with the dialysis center. The dialysis communication forms were incomplete. The clinical record review revealed that Resident #16 had been admitted to the facility 04/16/14. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, multiple sclerosis, chronic kidney disease, and depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/15/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section O (special treatments/procedures/programs) was coded to indicate the Resident received dialysis services. The Residents CCP (comprehensive care plan) included the focus area, needs dialysis. Interventions included, but were not limited to, dialysis 3 times a week and communicate with the dialysis center as indicated. The facility provided the surveyor with dialysis	F 698	F698 1. Resident #16 and 82 dialysis orders and communications forms were reviewed at the time of survey. 2. Current residents going to the dialysis center were audited to assure that orders are in place and proper monitoring of resident□s post dialysis is done. 3. DON/Designee educated staff on use of the post dialysis form and documentation of follow up care of residents by 6/18/19 4. Current residents post dialysis records will be reviewed at least 5 times per week then monthly times 2 by DON/Designee to assure that proper monitoring and follow up occurred. 5. Any non □ compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 698	Continued From page 24 communication forms dated 02/18/19-05/10/19. The facility provided the surveyor with copies of 14 dialysis communication forms. Of these 14 forms only one of these forms were complete. The administrative staff were notified of the issues regarding the Residents dialysis communication on 05/15/19 at 3:30 p.m. The facility provided the surveyor with a copy of their dialysis contract dated 04/01/13. This contract read in part, "...Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD (end stage renal disease) Residents..." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #82 the facility staff failed to coordinate care with the dialysis center. Resident #82 was admitted to the facility on 05/09/16 and readmitted on 04/25/19. Diagnoses included but not limited to anemia, coronary artery disease, congestive heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, end stage renal disease, diabetes mellitus, hyperlipidemia, hypothyroidism, cerebrovascular accident, hemiplegia, depression, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/02/19 coded the Resident as 14 out of 15 in section C, cognitive status. This is a significant change	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 698	Continued From page 25 MDS. Resident #82's CCP (comprehensive care plan) was reviewed and contained a care plan for "The Resident has dialysis". Interventions for this care plan include "communicate with dialysis as indicated". Resident #82's clinical record was reviewed on 05/16/19. It contained "Dialysis Communication Forms", with three sections. Section A is predialysis and includes meal provided to take to dialysis, medication required before dialysis and any change in condition before dialysis. This section is to be completed by the facility. Section B is to be completed by the dialysis center and contains pre and post weights, vital signs and any occurrences during dialysis. Section C is post dialysis upon return to the facility. The dialysis forms for 04/15/19, 04/26/19, 04/29/19, 05/01/19, 05/03/19, and 05/06/19 were all incomplete for section A, predialysis. The surveyor requested and was provided with a dialysis agreement form the contracting dialysis center, which read in part "The facility will provide for the interchange of information useful or necessary for the care of the Resident and will inform the ESRD Dialysis Unit of a contact person at the facility whose responsibilities include oversight of provision of dialysis services by the company and the ESRD Dialysis Unit to the Residents of the facility". The concern of the facility not coordinating care with the dialysis center was discussed with the dialysis center was discussed with the administrative team during a meeting on 05/16/19 at approximately 1600.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 698	Continued From page 26	F 698		
	No further information was provided prior to exit.			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 755	Continued From page 27 Based on staff interview, clinical record review, facility document review and in the course of a complaint survey the facility staff failed to ensure medications were available for administration for 1 of 27 Residents, Resident #55. The findings included: For Resident #55 the facility staff failed to ensure the medication Bactrim was available for administration. Resident #55 was admitted to the facility on 10/17/16 and readmitted on 08/02/18. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, multidrug-resistant organism, diabetes mellitus, hyperlipidemia, dementia, anxiety, depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/01/19 coded the Resident as 13 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #55's clinical record was reviewed on 05/15/19. It contained a physician's order summary for the months of December 2018 through February 2019, which read in part "Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth every 12 hours for MRSA (methicillin resistant staphylococcus aureus) for 7 days". This order was dated 01/30/19 with a start date of 01/30/19 and an end date of 02/06/19. Resident #55's eMAR's (electronic medication administration record) for the months of January	F 755	F 755 1. Resident 55 chart was reviewed, and MD was made aware we did not give the Bactrim as ordered due to allergies. 2. Audit was done of current residents to assure that allergies are flagged and appropriate and no one was receiving medications they were allergic to. 3. DON/Designee educated licensed staff on professional standards for documentation of medications and what to do if resident is allergic to medications by 6/18/19 4. DON/ Designee will monitor new orders at least 5 time weekly for 4 weeks and they monthly to assure that medications are given as ordered and no allergies noted with new orders. 5. Audits will be reviewed at the QAPI committee and any non-compliance will be reported for tracking and trending and progressive disciplinary action. 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 755	Continued From page 28 and February 2019 were reviewed. The eMAR contained an entry, which read in part "Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth every 12 hours for MRSA for 7 days". This entry was initialed as having been administered at 2100 (9 pm) on 01/30/19-02/05/19, and at 0900 on 02/02/19-02/03/19 and 02/05/19-02/06/19. The entry was coded as "5" on 01/31/19 at 0900, which is the equivalent of "hold/see progress notes". The entry was coded as "9" on 02/01/19 and 02/04/19 at 0900. Chart code "9" is equivalent to "other/see progress notes. Surveyor spoke with pharmacist #1 on 05/16/19 at approximately 0855 regarding Resident #55's Bactrim. Pharmacist #1 stated that they have no record of ever having dispensed the Bactrim for Resident #55. Surveyor spoke with pharmacist #2 on 05/16/19 at approximately 0930. Pharmacist #2 stated the pharmacy had never received an order for Bactrim for Resident #55, and had no record of the Bactrim having been sent to the facility nor did they have any record of it having been taken from the facility stat box. Surveyor spoke with the RNC (regional nurse consultant) on 05/1619 at approximately 0945. RNC stated that she had spoken with the pharmacy, and they had informed her that there was no record of the Bactrim being sent for Resident #55. RNC stated that she did not know where the Bactrim was obtained in order to be administered to Resident #55. Surveyor spoke with LPN (licensed practical	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 755	Continued From page 29 nurse) #1 on 05/16/19 at approximately 1455 regarding Resident #5. Surveyor asked LPN #1 if the Bactrim was in the medication cart, and she stated that she could not recall. Surveyor spoke with LPN #3 on 05/16/19 at approximately 1515. LPN #3 stated that she had pulled the Bactrim from the stat box to administer to Resident #55. Surveyor spoke with RN (registered nurse) #1 on 05/15/19 at approximately 1525. RN #1 stated that she did not really recall if she gave the Resident's Bactrim. Surveyor asked RN #1 if the Bactrim was in the medication cart and RN #1 stated that she could not recall. The concern of the facility not having the medication available for administration was discussed with the administrative team during a meeting on 05/16/19 at approximately 1600. No further information was provided prior to exit.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		6/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 880	Continued From page 30 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 880	Continued From page 31 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow established infection control guidelines for 1 of 27 Residents, Resident #46. The findings included: The facility staff failed to complete any hand hygiene during a dressing change to the Residents right heel. The clinical record review revealed that Resident #46 had been admitted to the facility 05/12/18. Diagnoses included, but were not limited to, muscle weakness, difficulty in walking, hypertension, venous insufficiency, pain, Parkinson's disease, and atrial fibrillation. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/22/19 included a BIMS (brief interview for mental status) summary score of 8 out of a	F 880	F880 1. Nurse that did not wash hand during the treatment pass was educated at the time of survey. 2. All staff is at risk of not washing hands with treatment pass. 3. Licensed staff were educated on proper standards of practice for hand washing with treatment pass by DON/Designee by 6/18/19 4. DON/Designee will monitor 3 nurse treatment pass per week times 4 weeks then monthly times 2 to assure that staff follow proper standards of practice for handwashing. 5. Any non- compliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed 6. 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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
F 880	Continued From page 32	F 880		

possible 15 points. Section M (skin conditions) was coded to indicate the Resident had 1 stage 3 pressure ulcer.

The Residents comprehensive care plan included the focus area has pressure ulcer right heel.

On 05/15/19 beginning at approximately 2:40 p.m., the surveyor observed LPN (licensed practical nurse) #1 complete wound care on the Residents right heel area. LPN #1 was assisted by RN (registered nurse) #1. When the surveyor entered the Residents room LPN #1 was observed to be wearing a pair of blue gloves. LPN #1 stated she had premedicated the Resident and used a 4X4 and saline to clean the Residents heel wound, LPN #1 then obtained another 4X4 and patted the wound dry, applied aquacel to the wound bed and covered the aquacel with dry gauze, wrapped the Residents right foot in kerlix, taped the kerlix in place, dated a piece of tape and applied it to the Residents dressing, and then applied a tubigrip over the dressing. At no time during this observation did LPN #1 complete any hand hygiene or change her gloves.

On 05/16/19 at 11:10 a.m., the DON (director of nursing) who was the designated infection control nurse was asked if she would have expected LPN #1 to complete any hand hygiene during this wound care. The DON stated the nurse should have completed hand hygiene between taking off the old dressing and applying the new one and between cleaning the wound.

The facility policy/procedure regarding hand hygiene during wound care was requested.

On 05/16/10 at 12:30 p.m., the DON provided the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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
F 880	Continued From page 33 surveyor with a copy of a policy titled "General Wound Care/Dressing Changes." This policy read in part, "...Licensed nurses will follow recognized standards of practice regarding dressing change(s)..." The facility standard of practice was requested of the DON but was never provided to the surveyor. Per the CDC (centers for disease control and prevention) website accessed 05/17/19. https://www.cdc.gov/handhygiene/providers/index.html "When and How to Perform Hand Hygiene...Before moving from work on a soiled body site to a clean body site on the same patient... After touching a patient or the patient's immediate environment...After contact with blood, body fluids or contaminated surfaces..." The administrative staff were notified of the issues regarding infection control during a meeting with the survey team on 05/16/19 at 3:57 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		