STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495183	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN AT BRANDERMILL WOODS	2100 BRANDERMILL PKWY MIDLOTHIAN, VA 23112

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/27/2017 through 6/29/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 3 closed record reviews (Residents #13 through #15).	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to follow the professional standards of practice for one Resident (Resident #10) in a survey sample of 15 residents. For Resident #10, the facility staff failed to ensure 2 medications were administered as ordered by a physician. The findings included;	F 281	**F-TAG – 281** In order to correct the findings identified by the Inspectors regarding Resident #10, staff failing to follow the professional standards of practice for Resident #10 and staff failing to ensure that (2) medications on (2) occasions were administered as ordered by a physician.	

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

Pamela Scott — Administrator — 7/13/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Resident #10, was admitted to the facility on 6-19-17. Diagnoses included; Benign Prostatic Hypertrophy, high cholesterol, pacemaker, glaucoma, vascular dementia, cardiomyopathy, depression, anxiety, and insomnia. Resident #10's most recent MDS (Admission minimum data set) was not completed, as he was a new Resident, however, the Resident was observed, and interviewed, and found to be confused and required extensive assistance with activities of daily living, and was a hospice Resident. Review of Resident #10's physician's orders, eMAR (electronic medication administration record), Nursing progress notes, and the facility printed MAR with notes, revealed that the Resident was not administered the following medications, on the following days. There were no notes documented by staff in the clinical record for the omissions other than "not observed" in the eMAR notes; 6-24-17 Coreg (high cholesterol medication) 3.125 milligrams to be given three times daily. The medication was omitted, and the reason given for the omission was documented in the eMAR notes, as, "not observed". No nursing notes document this omission. 6-25-17 Lorazepam (antianxiety medication) 1.0 mg (milligrams) tablet at 9:00 p.m. every day. The medication was omitted and the reason given for the omission was documented in the eMAR notes, as, "not observed". No nursing notes document this omission. The physician progress notes, and nursing	F 281	The following actions have been implemented: Upon discovery of Resident #10 not receiving (2) physician ordered medications, on (2) occasions, Coreg and Lorazepam, staff nurse was in-serviced on checking the medication record and following physician's orders. Staff nurse was in-serviced on checking the emergency stat box for medications not found in the resident's routine medication box. Staff nurse was in-serviced on the policy of contacting the pharmacy and/or physician for reordering medications and also in-serviced on the six (6) rights of Medications. There were no negative outcomes identified for this alleged deficient practice. In order to identify other residents having the potential to be affected, the Director of Nursing, or designee will review/audit 10% of the current census of Medication Administration Records to ensure correct and timely administration of resident's medications.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 281	Continued From page 2 progress notes were reviewed in their entirety for May, and June of 2017. There was no indication that the responsible party, nor the physician was ever made aware that these medication omissions occurred. Resident #3's care plan was reviewed, and stated "administer medications as ordered". On 6-28-17 at 4:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, physician progress notes, and nursing progress notes for May and June 2017. On 6-29-17 at 9:30 a.m. the DON was interviewed and stated, "I don't know why it was omitted, it is what it is." The Director of Nursing (DON) and Administrator provided the facility policy which stated to verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care. The DON stated "Mosby's" as their standard. Guidance for professional standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to	F 281	In order to prevent future incidents of residents not receiving medications, all licensed nursing staff will be in-serviced on the Medication Administration Policy, including the six (6) rights of Medications, and the Emergency Stat Box Policy. The Director of Nursing, or designee will audit all Medication Administration Records every week x (4) weeks, then every (2) weeks x (4) weeks, and quarterly thereafter until consistency is achieved. Any negative patterns will be presented monthly to the QA committee for reviews and/or recommendations. **Completion Date: 08/7/2017**	8/7/17

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F 281	Continued From page 3 an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medications were administered on 2 occasions for Resident #10 at the end of day debriefings on 6-28-17, and 6-29-17. No further information was provided by the facility.	F 281		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371	**F-TAG-371** In order to correct the findings identified by the Inspectors regarding 486.60(i)-(3) Food Procure, store/prepare/serve – sanitary, staff failing to prepare and serve food in a sanitary manner, related to the ice machine drain pipe in contact with the kitchen floor and having black mold along its length.	

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F 371	Continued From page 4 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to prepare and serve food in a sanitary manner. 1. The ice machine drain pipe was in contact with the floor and it had black mold along its length. Findings included: 1. The ice machine drain pipe was in contact with the floor and it had black mold along its length. During the tour of the kitchen on 6/27/2017 at 1:20 PM the ice machine was examined to assure that the drain pipe was situated properly, avoiding contamination of the ice. The drain pipe, which was a white plastic pipe approximately ¾" in diameter, was seen exiting the machine on the underside in the front. It went down to the floor and turned in a 90 degree angle toward the back of the underside of the machine. It was now lying on the floor for a distance of approximately 2'. The floor drain was located to the rear of the machine. In front of the drain was a short piece of 2" x 4" lumber. The pipe crossed on top of this wood which brought it off the floor, and the end of the pipe was now situated above the floor drain to facilitate draining. The white plastic pipe was seen to have black mold along the full length to the end of the pipe,	F 371	The following actions have been implemented: Immediately upon discovery of the inspector's findings, the equipment was pulled away from the immediate area of the ice machine and an employee thoroughly cleaned the underside of the machine and the pipe. Maintenance was called and the short piece of lumber that was holding the pipe above the ground was removed and replaced with proper drain tubing. There were no negative outcomes associated with this alleged deficient practice. To reduce the risk of future incidence, all dietary staff will be in-serviced on the proper procedures for maintaining clean floors, especially underneath all equipment in the kitchen and surrounding areas in or near the Dietary Department.	

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F 371	Continued From page 5 and the floor had dust, dirt and debris along the entire length of the ice machine. It was possible for the mold bacteria to enter the end of the pipe and travel to the ice storage area. An interview was immediately conducted with Employee C, Dietary Manager, who was unaware of the situation. At 2:00 PM on 6/27/2017 Employee D, Maintenance Supervisor, was seen cleaning the underside of the ice machine and repositioning the drain pipe. He stated that "mold could creep up the pipe into the ice machine". On 6/28/2017 at 4:00 PM Employee A, Facility Administrator was informed of the unsanitary condition of the ice maker. She stated that she was unaware of this situation. On 6/29/2017 at 10:00 AM, Employee E, Corporate Nutrition Director, stated that he was unaware of this situation and that it was repaired immediately. A review of the facility policies and procedures "Sanitation Inspection" was conducted and it stated "It is the policy of (facility) to maintain a food service area that is clean and sanitary". Administration was informed of the findings on 6/29/2017 at 11:30 AM.	F 371	In order to ensure that this is corrected for the future, a specific line item has been added to the "Monthly Dietary Audit" stating that "the ice machine and drainage pipe must be clean and free of mold and dirt. Also, the pipe must be at least 2 inches off the ground and positioned over the floor and in addition, all floors will be properly sanitized. The Dietary Manager or designee will complete a weekly report x (2) months and then monthly thereafter to assure adherence to policy and procedure. **Completion Date: 8/7/17**	8/7/17