STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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 1/10/17 through 1/11/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 bed certified facility was 108 at the time of the survey. The survey sample consisted of 19 current resident reviews (Residents #1 through #19) and 7 closed record reviews (Residents #20 through #26).	F 000		
F 160 SS=D	CONVEYANCE OF PERSONAL FUNDS UPON DEATH CFR(s): 483.10(f)(10)(v) (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to convey resident funds within 30 days of death for 1 of 26 residents in the survey sample; Resident #26.	F 160	F000 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, that facility has or will take the following actions set forth in the following plan of correction. The alleged	2/15/17

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

Electronically Signed | 01/27/2017

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F 160	Continued From page 1 The findings include: Resident #26 was admitted to the facility on 4/3/12 and expired on 6/23/16. The resident had diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, depression, and ischemic cardiomyopathy. The most recent MDS (Minimum Data Set) prior to death was a quarterly assessment with an ARD (Assessment Reference Date) of 4/4/16. The resident was coded as being cognitively intact to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing and dressing; limited assistance for transfers, ambulation, toileting and hygiene; independent for eating; and as continent of bowel and bladder. As part of a complaint, it was alleged that this resident's funds were not conveyed until "sometime in August 2016." The resident expired 6/23/16. A review of the "Resident Trust Check Request" documented a check was to be made payable to Resident #26's estate. This document was dated 8/12/16. A review of the check attached to this document revealed a "check date" of 8/15/16. This was approximately 53 days after the resident expired. On 1/11/17 at 9:55 a.m., in an interview with OSM #2 (Other Staff Member #2, the Business Office Manager), she stated that at the time the resident expired, she was new to the position, and thought	F 160	deficiencies cited have been or will be corrected by the date(s) indicated. F160 1)Resident #26 refunded on 8/15/16 2)All other resident accounts due refunds were reviewed, found up to date. 3)Business Office manager or designee reviews resident accounts for necessary resident refunds on a weekly basis. 4)Refund requests are reviewed weekly by CEO or designee to ensure ongoing compliance. 5)Complete date: 2/15/17	

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F 160	Continued From page 2 that she was told the facility had 60 days after death to convey funds. A review of the facility policy provided, "Resident Funds" (revised 11/2016) documented, "7. Upon discharge, death or eviction of the resident, monies remaining in the fund will be sent to his/her forwarding address within thirty (30) days. This period of time is needed in order to satisfy any legitimate charges against the fund...." On 1/11/17 at 10:45 a.m., the CEO/Administrator (ASM #1 - Administrative Staff Member) and the Director of Compliance (ASM #3) were made aware of the findings.	F 160		
F 431 SS=D	COMPLAINT DEFICIENCY DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		2/15/17

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F 431	Continued From page 3 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure medications were not expired in one of three	F 431	F431 1)All items identified as expired were discarded by the contract pharmacy.	

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F 431	Continued From page 4 facility medication rooms. On the "Grace Unit" in the medication room STAT (2) cabinet A 10mL (milliliter) bottle of Citrate (1) with an expiration date of 12/16 was found available for resident use and a STAT box available for resident use, labeled number 9 (nine) had a sticker on it that documented, "Expiration Date: 12/16". The findings included: On 1/10/17 at approximately 1:00 p.m., the "Grace Unit" medication room was inspected with LPN (licensed practical nurse) #1. During this time, a 10mL (milliliter) bottle of Citrate (1) with an expiration date of 12/16 was found in the STAT cabinet of the medication room. Further inspection of the STAT cabinet revealed a STAT box labeled number 9 (nine) had a sticker on it that documented, "Expiration Date: 12/16." Further observation of the STAT box revealed a label that documented the contents of the box: 5 (five)ml Heparin syringe flushes, 10ml Sodium Chloride syringe flushes and one Carpuject Holder. An interview was conducted with LPN (licensed practical nurse) # 1 on 1/10/17 at approximately 1:10 p.m. LPN # 1 acknowledged that the bottle of Citrate and STAT box number nine was expired. LPN # 1 stated, "These should have been changed out by the pharmacy." On 1/10/17 at 1:40 p.m. an observation of the medication room on the "Grace Unit" was conducted with OSM (other staff member) # 1, pharmacy technician. OSM # 1 observed STAT box number nine and acknowledged that it had a	F 431	2)Corporate office of the contractor was notified immediately of the findings and all pharmacy STAT boxes were inspected, no further issues identified. 3)Contractor presented proof of Pharmacist educated on their policy for STAT boxes 4)STAT box inspections will be logged and reports presented to the director of compliance for ongoing review by the QA committee for additional recommendations. 5)Complete date: 2/15/17	

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sticker on it that documented, "Expiration Date: 12/16." OSM # 1 then opened the STAT box and inventoried the contents. The box contained 12-five ml (milliliter) Heparin syringe flushes, 15-10ml Sodium Chloride syringe flushes and one Carpuject Holder. Four of the Heparin syringe flushes documented expiration dates of 12/16.

An interview was conducted with OSM # 1 on 1/10/17 at approximately 1:45 p.m. When asked about the expired STAT box and the expired Heparin syringe flushes, OSM # 1 stated, "These were the items in the STAT box that were going to expire on 12/2016, that's why there was an expiration sticker on the box dated 12/16. When asked about the procedure to ensure expired items were not available for use, OSM # 1 stated, "Pharmacy checks the boxes (STAT boxes) two times a week. It should have been picked up, it was overlooked." When asked about the expired Citrate found in the STAT cabinet of the medication room on the "Grace Unit", OSM # 1 stated, "It should have been picked up as well."

The facility's policy "STAT Box" documented, "C. OWNERSHIP: The contents of the STAT Box are the property of the pharmacy and therefore, shall not be used or altered in any way except as outlined in the forgoing. [Name of Pharmacy] shall be responsible for maintaining the inventory of the STAT Box. [Name of Pharmacy] shall be responsible for removing any medication that is outdated. D. MONITORING BY THE PHARMACIST. 1. A [Name of Pharmacy] Pharmacist is responsible for checking the sealing and storage of the STAT Box, and the expiration date on the outside of the STAT Box. 2. The Pharmacist will check the STAT Boxes

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bi-weekly for dating and accuracy and will restock as needed."

On 1/11/17 at 9:40 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings

No further information was provided by the end of the survey.

References:

(1) Use for relief of occasional constipation (irregularity). Generally produces bowel movement in 1/2 to 6 hours. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=83d52e05-7c2b-4811-915e-7ce359282a3b.

(2) Immediately. This information was obtained from the website: https://www.merriam-webster.com/dictionary/stat.

(3) Heparin Lock Flush Solution, USP is a sterile, nonpyrogenic, hypertonic preparation of heparin sodium injection, USP with sodium chloride in water for injection. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=dd4944b6-9d6e-4180-bb68-c0516a27a379.

(4) Sodium Chloride Injection is used to flush intravascular catheters or as a sterile, isotonic single dose vehicle, solvent, or diluent for substances to be administered intravenously, intramuscularly or sub-cutaneously and for other

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F 431	Continued From page 7 extemporaneously prepared single dose sterile solutions according to instructions of the manufacture of the drug to be administered. . This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7e316d21-d6ad-4976-bd90-268fd7e51361. (5) The carpuject is a syringe device for the administration of injectable fluid medication. It is designed with a leur-lock device to accept a sterile hypodermic needle or to be linked directly to intravenous tubing line. The product can deliver an intravenous or intramuscular inject by means of a special holder which attaches to the barrel and plunger the attaches to the barrel plug. Medication is prefilled into the syringe barrel. When the plug at the end of the barrel is advanced to the head of the barrel it discharges and releases the contents through the needle or into the lumen of the tubing. This information was obtained from the website: http://dictionary.sensagent.com/carpuject/en-en/.	F 431		
F 507 SS=D	LAB REPORTS IN RECORD - LAB NAME/ADDRESS CFR(s): 483.50(a)(2)(iv) (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 507	F507 1)A copy of Resident #9's lab report for	2/15/17

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F 507	Continued From page 8 the facility staff failed to file laboratory results in the clinical record for one of 26 residents in the survey sample, Resident #9. The results of a BMP (basic metabolic panel) (1) done 1/22/16, was not filed in the clinical record for Resident #9. The findings include: Resident #9 was admitted to the facility on 10/19/09 with diagnoses that included but were not limited to: shoulder pain, cellulitis, Alzheimer's disease, edema, peripheral vascular disease and gastroesophageal reflux disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/27/16 coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living except eating, in which she was coded as independent after set up assistance was provided. The physician orders dated, 1/4/14, documented, "Obtain BMP (basic metabolic panel (1)) every 6 months." Review of the clinical record revealed the "Treatment Administration Record (TAR)" for January 2016. The TAR documented, "Obtain BMP every 6 months." The box for 1/22/16 was checked off indicating that the test was completed. The results of a BMP dated, 8/10/16 was found in the clinical record. There were no results for	F 507	1/22/16 has been requested from the lab. 2)An audit will be completed for labs to ensure they are currently filed on the clinical records. 3)On a monthly basis lab audits will be performed to ensure labs for the previous month are filed in the clinical record. 4)Audits will be reviewed by the QA committee on an ongoing basis for additional recommendations. 5)Compete date: 2/15/17	

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January or February 2016.

A copy of the BMP results for January or February 2016 was requested from ASM (administrative staff member) #3, the director of compliance on 1/11/17 at approximately 10:00 a.m.

The administrator, ASM #1 and ASM #3, director of compliance, were made aware of the above findings on 1/11/17 at 1:00 p.m.

On 1/11/17 at 1:36 p.m., ASM #3, the director of compliance, stated that she had no further information regarding the laboratory results.

An interview was conducted with LPN (licensed practical nurse) #3 on 1/11/17 at 2:00 p.m. When asked about the process followed by staff for obtaining a physician ordered laboratory test, LPN #3 stated, "You get the physician order. You put it in the lab (laboratory) book. When I come in I check what labs are to be drawn on my residents. I draw the lab, send it to the hospital. They (the hospital) send the results by fax, unless it was STAT (Immediately (2)) or has a critical result, then they call us. We mark down that the results were received."

On 1/11/17 at approximately 2:15 p.m. ASM #3 was asked to locate the lab tracking form for January 2016.

On 1/11/17 at approximately 2:25 p.m. ASM #3 stated she could not locate the tracking form but was able to locate an audit form that documented the resident did have the test and at the time of the audit, the results were in the clinical record. A policy was requested at that time for tracking

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F 507	Continued From page 10 laboratory test results. The facility policy, "Documentation Guidelines" documented, "The facility may document information on any form and/or format used in the facility such as written flow sheets, electronic charts, forms, etc. The Documentation Guidelines are not meant to be mandated all documentation requirements for each specific procedure. However, each employee responsible for resident care and services are expected to accurately and completely document all care and services after it is provided and prior to leaving duty on their assigned shift. Failure to complete documentation will result in disciplinary action including termination depending on the circumstance surrounding the breach of documentation." No further information was provided prior to exit. (1) The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism: This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/002257.htm>. (2) Immediately. This information was obtained from the website: https://www.merriam-webster.com/dictionary/stat.	F 507		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		2/15/17

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F 514	Continued From page 11 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample, Resident #2.	F 514	F514 1)The nurse for Resident #2 was educated on the importance of documentation of nonpharmocological interventions she provides, as it related to	

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F 514	Continued From page 12 For Resident #2, facility staff failed to document that non-pharmacological interventions were attempted prior to the administration of Haldol [1]. The findings include: Resident #2 was admitted to the facility on 2/5/13 with diagnoses that included but were not limited to convulsions, dementia with behaviors, atrial-fibrillation, insomnia, anxiety, and diabetes. Resident #2's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/16/16. Resident #2 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #2 was coded as requiring extensive assistance from staff with transfers, eating, and hygiene; and total dependence on staff with locomotion and bathing. Review of Resident #2's November and December 2016 MAR (Medication Administration Records) revealed the following order: "Haloperidol (Haldol) [1] 2 MG (milligram) tablet by mouth every 4 hours as needed for psychosis." This order was initiated on 1/4/15 and discontinued on 12/12/16. Review of the November 2016 MAR revealed that Resident #2 had been administered Haldol on 11/30/16 at 6:41 p.m. The following note was documented: "6:41 PM, 11/30/16 (Administered: 6:41 PM, 11/30/16; HALOPERIDOL 2 MG TABLET) ...give 1 tablet daily...resident verbal loud and verbal. disruptive (sic). grinding (sic) teeth. given (sic) haldol prn (as needed) at 6:45."	F 514	PRN haldol use. 2)All nurses were re-educated on the documentation of nonpharmocological interventions they provide prior to PRN medication use 3)Random documentation audits will be performed on a monthly basis for documentation of nonpharmological intervention documentation for PRN medications. 4)Audits will be reviewed by the QA committee on an ongoing basis for additional recommendations. 5)Compete date: 2/15/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 514	Continued From page 13	F 514		

Review of the nursing notes failed to document non-pharmacological interventions attempted prior to the administration of Haldol on 11/30/16.

Review of the December 2016 MAR revealed that Resident #2 had been administered Haldol on 12/5/16. The following note was documented, "6:27 PM, 12/05/16 (Administered: 6:27 PM, 12/5/16; HALOPERIDOL 2 MG TABLET) HALOPERIDOL 2 MG Tablet give 1 tablet by... . (sic) resident restless. haldol (sic) given per prn order at 6:30..."

Review of the nursing notes failed to document non-pharmacological interventions attempted prior to the administration of Haldol on 12/5/16.

On 1/11/17 at 11:37 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4, the nurse who administered Haldol to Resident #2 on 11/30/16 and 12/5/16. LPN #4 was asked about the process followed when administering a prn (as needed) anti-psychotic medication to a resident. LPN #4 stated that she would first assess the resident to see what type of behaviors they were experiencing, and then she would try non-pharmacological interventions before administering medication. LPN #4 stated that she would document the non-pharmacological interventions attempted in a nurses note. When asked if she was familiar with Resident #2, LPN #4 stated that she had spent a lot of time with Resident #2. LPN #4 stated that Resident #2 becomes very agitated at times and grinds her teeth during this time. LPN #4 stated that she tries to offer the resident fluids, massage her hand, or dim the lights in attempts to decrease her agitation. LPN #4 stated that she

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F 514	Continued From page 14	F 514		

always tries non-pharmacological interventions before giving Resident #2 her prn Haldol. LPN #4 stated that she forgot to document these interventions in the clinical record.

On 1/11/17 at 12:25 p.m., ASM (administrative staff member #1), the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Director of Compliance were made aware of the above findings.

Facility policy titled, "Medication Administration" did not address documenting non-pharmacological interventions prior to the administration of prn anti-psychotics. No further information was presented prior to exit.

[1] Haldol- Used to treat symptoms of mental and emotional disorders and severe behavioral problems. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010537/?report=details.