PRINTED: 05/29/2018

		AND HUMAN SERVICES MEDICAID SERVICES			FORM APP MB NO. 093	PROVE
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER 495252		(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SUR COMPLET	RVEY
			B. WING	i <u></u>	R-C 05/17/2)018 [°]
	PROVIDER OR SUPPLIER FIELD PARK HEALTH	CARE CENTER		<u> </u>	.010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COM	(X5) PLETION DATE
{E 000}	Initial Comments		{E 00	00} This plan of correction is prep	ared	
{F 000}	An unannounced Emergency Preparedness re-visit survey was conducted 5/16/18 through 5/17/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey. INITIAL COMMENTS		{F 00	and executed because it is recovered by the provisions of state and law not because Battlefield Pattlefield Pattle	federal ark denies and	- •-
	conducted 5/16/18 to conducted 3/20/18 to are required for corr CFR Part 483 Feder	ledicare/Medicaid revisit was through 5/17/18 for the survey through 3/29/18. Corrections appliance with the following 42 ral Long Term Care complaints were investigated.		CommuniCare, Battlefield Par HealthCare Center maintains alleged deficiencies do not jeopardize the health and safe the residents, nor is it of such character as to limit our capal	that the	
{F 755} SS=D	The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #101 through #113) and 1 closed record review (Residents #114). [755] Pharmacy Srvcs/Procedures/Pharmacist/Records SS=D CFR(s): 483.45(a)(b)(1)-(3)		{F 75	render adequate care. To remain in compliance with federal and state regulations, facility has taken or will take t	all the he	
:	drugs and biologicals them under an agree §483.70(g). The fac	vide routine and emergency s s to its residents, or obtain		Date of Compliance: May 23, 2	VDH/OLC	JUN 0 1 2018
	permits, but only und a licensed nurse.	der the general supervision of		F 755 1.) Resident #104's physician wa	OLC	1 2018
	§483.45(a) Procedur	es. A facility must provide		notified of IV antibiotic not being	4,5	

biologicals) to meet the needs of each resident. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

pharmaceutical services (including procedures

that assure the accurate acquiring, receiving.

dispensing, and administering of all drugs and

TITLE (X6) DATE

available from the pharmacy, with no

adverse side effects noted.

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BXH212

Facility ID: VA0021

PRINTED: 05/29/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C 495252 **B. WING** 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **BATTLEFIELD PARK HEALTHCARE CENTER** PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE

{F 755} Continued From page 1

§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 bv:

Based on interview, clinical record review and facility documentation the facility failed for 1 resident (Resident #104) to provide medications as ordered by the physician.

Findings included:

Resident #104 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube.

Review of the clinical record showed Resident #104 was ordered Zosyn 3.375 grams (antibiotic for pneumonia) to be administered intravenously (IV) four times per day for seven days to begin at 8:00 PM on 5/14/18.

{F 755}

TAG

2.) Current residents will be reviewed to ensure Physician ordered IV antibiotics are available in a timely manner from the pharmacy, any identified concerns will be addressed as indicated.

DEFICIENCY)

- 3.) Licensed nurses will be educated on or before 5/23/2018 on the process for when IV antibiotic medications are unavailable from the pharmacy, procedures for checking first dose machine, and following up with pharmacy for arrival time or contact physician for alternative drug by Unit Manager and/or designee.
- 4.) DON/Designee will review all new orders for IV antibiotics three times a week x 12 weeks to ensure IV antibiotics are administered in a timely manner with results brought to QAPI x 3 months.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BXH212

Facility ID: VA0021

If continuation sheet Page 2 of 6



PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			 -	R-C	
	495252	B. WING		05/17/2018	
NAME OF PROVIDER OR SUPPLIE		25	REET ADDRESS, CITY, STATE, ZIP CODE 0 FLANK ROAD ETERSBURG, VA 23805		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
Administration Redocumentation of 5/14/18 at 8:00 Pl 5/15/18 at 8:00 Pl 5/15/18 at 12:00 Pl 5/15/18 at 4:00 Pl 5/15/18 at 4:00 Pl 5/15/18 at 8:00 Pl Review of nurses stated that Reside yet arrived from pl NP (nurse practitional hold medications of The note went on to the facility on the During interview we facility policy that it medication available pharmacy and the from the back up pet the Dr. and let him substitute it or put During interview we facility policy if the the first dose box to pharmacy and see up pharmacy. She it from the back up call the MD or NP at 15/15/15/15/15/15/15/15/15/15/15/15/15/1	y 2018 Medication administration of the Zosyn. M M M M M M M M M M M M M M M M M M	(F 755)			
Review of the facility medication showed	y policy for unavailable the following:	; : :			
"3. In the event the	medication is not available				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BXH212

Facility ID: VA0021

If continuation sheet Page 3 of 6



PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		405050	D 147510		R-C	
		495252	B. WING		05/17/2018	
BATTLE	PROVIDER OR SUPPLIER FIELD PARK HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
{F 760} SS=E	charge nurse will not to receive a HOLD of medication that is conceived and the conceive an	e Emergency Pharmacy, the tify the Physician immediately order or a change in urrently available." medications in the First Dose should have been 2 doses of available in first dose box. ration was made aware y conference at 11:30 AM on information was provided. of Significant Med Errors ure that its-ints are free of any significant is not met as evidenced clinical record review and in the facility failed for 1 in 104) to provide five doses of monia resulting in a interior. dmitted to the facility on es to include but not limited to trachea, traumatic brain which Accident in pressure ulcer stage II and record showed Resident syn 3.375 grams (antibiotic	{F 76	1.) Resident #104's physician notified of IV antibiotic not be immediately available, with readverse side effects noted. 2.) Current residents will be read to ensure Physician ordered I antibiotics are available in a temanner, any identified concerbe addressed as indicated. 3.) Licensed nurses will be ed on or before 5/23/2018 on the process for when IV antibiotics medications are unavailable for pharmacy, procedures for chefirst dose machine, and follow with pharmacy for arrival time contact physician for alternations.	eing eviewed V imely rns will ucated e com the ecking ring up e or	
i F F	njury due to Motor Ve Hydrocephalus, sacra Peg tube. Review of the clinical #104 was ordered Zos	Phicle Accident If pressure ulcer stage II and record showed Resident		pharmacy, procedures for che first dose machine, and follow with pharmacy for arrival time	ecking ring up e or ve drug	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: BXH212

Facility ID: VA0021

If continuation sheet Page 4 of 6



PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTR	UCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING			R-6	C 7/2018	
	PROVIDER OR SUPPLIER	CARE CENTER		250 FLANK	PRESS, CITY, STATE, ZIP CODE ROAD URG, VA 23805	<u> </u>	112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	(<u>(</u> EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 760}	Continued From pa	ge 4	{F 76	iO}				
	IV) four times per d 8:00 PM on 5/14/18	ay for seven days to begin at	•	4	.) DON/Designee will review orders for IV antibiotics three			
	: Review of the May	2018 Medication			veek x 12 weeks to ensure IV			
		ord (MAR) revealed missing		a	ntibiotics are administered ir	а		
		dministration of the Zosyn.		ti	mely manner with results bro	ought		
	5/14/18 at 8:00 PM	-			QAPI x 3 months.		•	
	5/15/18 at 8:00 AM	•	•					
	5/15/18 at 12:00 PM 5/15/18 at 4:00 PM	1						
	5/15/18 at 8:00 PM					-		
	stated that Resident yet arrived from pha NP (nurse practition hold medications un The note went on to to the facility on the	otes dated 5/15/18 at 3:00 PM 104's IV antibiotics had not rmacy. The nurse called the er) to obtain a new order to til arrival from pharmacy. say pharmacy would have it late night run on 5/15/18.						
	facility policy that if the medication available pharmacy and then if from the back up pharmacy and the phar	LPN B she stated it is the he facility doesn't have the he facility doesn't have the he facility will call the f the pharmacy can't get it armacy, the facility will call now and see if he can on hold.						
	facility policy if the m the first dose box the pharmacy and see if up pharmacy. She a it from the back up pi call the MD or NP an	DON she stated it was edication was not available in nurse was to notify the they could get it from a back lso stated if they couldn't get harmacy the facility would d see if they could substitute hold until the pharmacy could						
		policy for unavailable						
ORM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: BXH212		acility ID: VA0021	If continue			

Facility ID: VA0021

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If continuation sheet Page 5 of 6

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PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
·	495252	B. WING		R-C
NAME OF PROVIDER OR SUPPLIER BATTLEFIELD PARK HEALTH			STREET ADDRESS, CITY, STATE 250 FLANK ROAD PETERSBURG, VA 23805	05/17/201
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE
{F 760} Continued From pa		{F 760	D)	
from the E-Kit or the		:		
box revealed there s	medications in the First Dose should have been 2 doses of available in first dose box.			
during the end of day	ration was made aware y conference at 11:30 AM on information was provided.			
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•				
M CMS-2567(02-99) Previous Versions Ob	solete Event ID: BXH212		cility ID: VA0021	

Facility ID: VA0021

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If continuation sheet Page 6 of 6

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				TING NO							
TETHOD OF PRESE	NTATION:	(Lecture, De	monstration, Films & etc.)		LECTU	RE AND I	DISCUSS	ON			
		J.Ÿ	. Antibiotics	s and	Ava	ilabil	ity-				
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495252	B. WING		R-C 05/17/		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2010	
				250 FLANK ROAD			
BATTLE	FIELD PARK HEALTH	CARE CENTER		PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LDBE C	(XS) OMPLETION DATE	
{E 000}	Initial Comments		{E 00				
				This plan of correction is p	epared		
	An unannounced E	mergency Preparedness		and executed because it is	required		
		conducted 5/16/18 through		by the provisions of state a	nd federal		
	5/17/18. The facility	y was in substantial		law not because Battlefield	Park	ĺ	
	compliance with 42			HealthCare Center admits	or denies	,	
		ng-Term Care Facilities. No		the validity of the allegatio	ns and		
		vestigated during the survey.	:				
{F 000}	INITIAL COMMENT	S	{F 00	Statement of Deficiencies.	3 OI till3		
)		
		Medicare/Medicaid revisit was		CommuniCare, Battlefield			
		through 5/17/18 for the survey		HealthCare Center maintai	is that the	•	
		through 3/29/18. Corrections		alleged deficiencies do not			
	CFR Part 483 Fede	npliance with the following 42		jeopardize the health and s	afety of	· ·	
		omplaints were investigated.		the residents, nor is it of su	ch		
	1			character as to limit our ca	pability to		
	The census in this 1	20 certified bed facility was		render adequate care.	•		
		e survey. The survey sample					
		ent Resident reviews		. To remain in compliance w	th all	ľ	
		ough #113) and 1 closed		federal and state regulation	is, the		
(F 255)	record review (Resid			facility has taken or will tak	e the		
		ocedures/Pharmacist/Records	{F 75	5)! actions set forth in the follo	wing plan	ļ	
SS=D:	CFR(s): 483.45(a)(b)(1) - (3)		of correction:	G F	i	
	§483.45 Pharmacy \$	Services				İ	
	The facility must pro	vide routine and emergency				.	
	drugs and biological	s to its residents, or obtain		Date of Compliance: May 2:	2010		
	them under an agree	ement described in		Date of Compliance, May 2:	, 2016	<u> </u>	
	9483.70(g). The fac	cility may permit unlicensed			7	- 0	
	personner to adminis	ster drugs if State law der the general supervision of		F 755	Č	5 -	
	a licensed nurse.	der the general supervision of			8, 2018	JUN 0 1 2018	
	- avoitoga italog.			1.) Resident #104's physician	was 🦲		
	§483.45(a) Procedu	res. A facility must provide		notified of IV antibiotic not be		·]	
	pharmaceutical serv	ices (including procedures		available from the pharmacy,	_	j	
	that assure the accu	rate acquiring, receiving,		adverse side effects noted.			
	dispensing, and adm	ninistering of all drugs and		autoria de arread noted,			
	biologicals) to meet	the needs of each resident.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Dipector

(X6) DATE 5/2///

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	<u>. 0938-039</u> 1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTR ING		CON	E SURVEY APLETED R-C
		49 5252	B. WING			05/	17/2018
	PROVIDER OR SUPPLIER FIELD PARK HEALTH	CARE CENTER		250 FLANK	RESS, CITY, STATE, ZIP CODE ROAD URG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDERS PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	must employ or obte pharmacist who- §483.45(b)(1) Provisus pects of the provision the facility. §483.45(b)(2) Establic receipt and disposition sufficient detail to entereconciliation; and §483.45(b)(3) Deterected and that an action is maintained and performed and that an action is maintained and performed and interview, facility documentation resident (Resident # as ordered by the performance included: Resident #104 was a 3/15/18 with diagnost to Bronchitis related injury due to Motor Verydrocephalus, sacribed to the clinical Review of the clinical	Consultation. The facility ain the services of a licensed des consultation on all sion of pharmacy services in dishes a system of records of on of all controlled drugs in hable an accurate mines that drug records are in able an accurate drugs ariodically reconciled. To is not met as evidenced clinical record review and an the facility failed for 1 104) to provide medications sysician.	{F 7:		2.) Current residents will be a to ensure Physician ordered antibiotics are available in a manner from the pharmacy, identified concerns will be act as indicated. 3.) Licensed nurses will be eon or before 5/23/2018 on the process for when IV antibiotic medications are unavailable pharmacy, procedures for charmacy, procedures for charmacy for arrival time contact physician for alternative Unit Manager and/or desured the conders for IV antibiotics three week x 12 weeks to ensure a antibiotics are administered timely manner with results by OAPI x 3 months.	itimely any ducated ducated he ic from the necking wing up ne or ative drug ignee. w all new e times a V in a	
1	for pneumonia) to be	administered intravenously (y for seven days to begin at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BXH212

Facility ID: VA0021

If continuation sheet Page 2 of 6



PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495252	B. WING			R-C
NAME OF	DOOMDED OD GUDDIUED		1			<u>5/17/2018</u>
•	PROVIDER OR SUPPLIER FIELD PARK HEALTH	CARE CENTER		STREET ADDRESS, CITY, STATE, 250 FLANK ROAD PETERSBURG, VA 23805	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	documentation of at 5/14/18 at 8:00 PM 5/15/18 at 8:00 PM 5/15/18 at 12:00 PM 5/15/18 at 12:00 PM 5/15/18 at 4:00 PM 5/15/18 at 8:00 PM Review of nurses no stated that Resident yet arrived from pha NP (nurse practition hold medications un The note went on to to the facility on the During interview with facility policy that if the medication available pharmacy and then if from the back up phase the first dose box the charmacy and see if up pharmacy. She at from the back up pleall the MD or NP and see if th	2018 Medication ord (MAR) revealed missing dministration of the Zosyn. It is dated 5/15/18 at 3:00 PM is 104's IV antibiotics had not rmacy. The nurse called the er) to obtain a new order to till arrival from pharmacy, say pharmacy would have it late night run on 5/15/18. ILPN B she stated it is the the facility doesn't have the facility will call the fithe pharmacy can't get it armacy, the facility will call how and see if he can	{F 758			
F n	Review of the facility nedication showed the	policy for unavailable ne following: edication is not available				
	o. III uie event the m	edication is not available				

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Event ID: BXH212

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If continuation sheet Page 3 of 6



PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<u> </u>
		495252	B. WING		R-C	
NAME OF	PROVIDER OR SUPPLIER	700202		STREET ADDRESS, CITY, STATE, ZIP	05/17/2018	_
	FIELD PARK HEALTH	CARE CENTER		250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION	ж
{F 760}	charge nurse will not to receive a HOLD of medication that is concentration and the facility administration that the facility administration that the facility administration that the facility administration errors. The facility must ensignate that the facility must ensigned that the facility documentation resident (Resident #104 was a 3/15/18 with diagnost to Bronchitis related the injury due to Motor Volumentation of the facility documentation for promotion	e Emergency Pharmacy, the stify the Physician immediately order or a change in currently available." medications in the First Dose should have been 2 doses of available in first dose box. ration was made aware y conference at 11:30 AM on information was provided. For Significant Med Errors sure that its-ents are free of any significant. T is not met as evidenced clinical record review and in the facility failed for 1 (104) to provide five doses of amonia resulting in a in error. Idmitted to the facility on est to include but not limited to trachea, traumatic brain ehicle Accident all pressure ulcer stage II and	{F 76	1.) Resident #104's photified of IV antibioticimmediately available adverse side effects n 2.) Current residents to ensure Physician or antibiotics are availabed manner, any identified be addressed as indicated as	ic not being t, with no toted. will be reviewed rdered IV le in a timely d concerns will ated. If be educated 18 on the ntibiotic ailable from the is for checking d following up ival time or	
	#104 was ordered Zo	record showed Resident syn 3.375 grams (antibiotic administered intravenously (contact physician for a by Unit Manager and/o		

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Event ID: BXH212

Facility ID: VAD021

If continuation sheet Page 4 of 6



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PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495252	B. WING		R-C 05/17/2018		
7.4	PROVIDER OR SUPPLIER FIELD PARK HEALTH	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 250 FLANK ROAD PETERSBURG, VA 23805		11/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	8:00 PM on 5/14/18 Review of the May: Administration Recidocumentation of a 5/14/18 at 8:00 PM 5/15/18 at 12:00 PM 5/15/18 at 12:00 PM 5/15/18 at 4:00 PM 5/15/18 at 4:00 PM Feview of nurses not stated that Resident yet arrived from phanch NP (nurse practition hold medications unthe note went on to to the facility on the During interview with facility policy that if the medication available pharmacy and then from the back up pharmacy and see if up pharmacy and see if up pharmacy. She alt from the back up pharmacy and see if the MD or NP and the med or put it on I bring it.	ay for seven days to begin at 3. 2018 Medication ord (MAR) revealed missing dministration of the Zosyn. At 104's IV antibiotics had not armacy. The nurse called the er) to obtain a new order to still arrival from pharmacy. say pharmacy would have it late night run on 5/15/18. The LPN B she stated it is the the facility doesn't have the extended the pharmacy can't get it armacy, the facility will call now and see if he can	{F 76	4.) DON/Designee will orders for IV antibiotics week x 12 weeks to ensantibiotics are administ timely manner with resto QAPI x 3 months.	s three times a sure IV tered in a		

Event ID: BXH212

Facility ID: VA0021

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If continuation sheet Page 5 of 6

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FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
]		495252	B. WING		R-C
NAME OF	PROVIDER OR SUPPLIER	450202	D. WALAG		05/17/2018
NAME OF	FROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD	
BATTLE	FIELD PARK HEALTH	CARE CENTER		PETERSBURG, VA 23805	•
(24) 12	CUMMADVETA	TEMENT OF DEFICIENCIES			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
{F 760}	Continued From pag	-	{F 760) }	
	medication showed	the following:		,	
	"3. In the event the refrom the E-Kit or the charge nurse will no to receive a HOLD of medication that is cultured with the control of the list of box revealed there is Zosyn 3.375 grams at the facility administration of day	medication is not available Emergency Pharmacy, the tify the Physician immediately order or a change in			

Event ID: BXH212

Facility ID: VA0021

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If continuation sheet Page 6 of 6

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attlefield Park 00249		Jacq	ueline	Collin	15	5-21-	18	
		MEE	TING NOTES					
ETHOD OF PRESENTAT	ION: (Lecture, D				.			
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, NURSES: RN'	s and LPN's	
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Resident	IV Antibiotic	Date Ordered	Date Stopped	Comments
1.) Custo Brooks	Zaiyn Iv	5/21/18	4/5/18	Aspire order misself until 6/5/18 Doses
2.) Jackie Purdy	Vancomycin	5/24/18	(0/3/rx	Active Order (D) until 6/3/18 Sapa
1.) Curtis Brooks 2.) Jackie Purdy 3.) Martha Walker	Vancomycin	slzyliz	4/3/18	Until 6/3/18 Dose
4.)		74		
5.)				
6.)	_			
7.)				
8.)				
9.)		, , , , , , , , , , , , , , , , , , ,		
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