PRINTED: 09/12/2018 FORM APPROVED OMB NO. 0938-0391

E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted 7/9/18 through 7/12/18. The facility was a conducted 7/9/18 through 7/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/9/18 through 7/12/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Faderal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 57 certified bed facility was 47 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. F 684 Quality of Care Quality of Care Quality of Care 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 staff interview, facility document review, and clinical record review, the facility yrasty staff		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	80 50	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
BLAND COUNTY NURSING & REHABILITATION CENTER CAN ID REPORT SUMMARY STATEMENT OF DEFICIENCIES 12185 GRAPEFIELD ROAD BASTIAN, VA 24314			495191	B. WING		175	
PRÉRIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted 7/9/18 through 7/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-term Care Facilities. One complaint was investigated during the survey. F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/9/18 through 7/12/18. One complaint was investigated during the survey. F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 7/9/18 through 7/12/18. One complaint was 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 57 certified bed facility was 47 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. F 684 SS=0 CFR(s): 483.25 § 483.25 Quality of care Quality of Care 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 staff interview, facility document review, and clinical record review, the facility staff	255 (2000)		REHABILITATION CENTER		12185 GRAPEFIELD ROAD	1 0712510	
An unannounced Emergency Preparedness survey was conducted 7/9/18 through 7/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/9/18 through 7/12/18. One complaint was 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 57 certified bed facility was 47 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. F 684 SS=D S=0 S=0 S=0 S=0 S=0 S=0 S=	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP	DBE COMPLETION	
survey was conducted 7/9/16 through 7/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 7/9/18 through 7/12/18. One complaint was 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 57 certified bed facility was 47 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. F 684 Quality of Care SS=D CFR(s): 483.25 § 483.25 Quality of care 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 staff interview, facility document review, and clinical record review, the facility staff	E 000	Initial Comments		ΕO	00		
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at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. F 684 Quality of Care F 684 8/10/18 CFR(s): 483.25 § 483.25 Quality of care Quality of care 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 staff interview, facility document review, and clinical record review, the facility staff		survey was conducted One complaint was survey. Corrections with 42 CFR Part 4 requirements. The	ted 7/9/18 through 7/12/18. investigated during the s are required for compliance 83 Federal Long Term Care Life Safety Code				
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 staff interview, facility document review, and clinical record review, the facility staff		at the time of the su consisted of 12 cur closed record revie Quality of Care	urvey. The survey sample rent Resident reviews and 3	F 68	84 :	8/10/18	
review, and clinical record review, the facility staff		Quality of care is a applies to all treatment facility residents. By assessment of a restraction that residents received accordance with propractice, the compressive plan, and the residents REQUIREMENT by:	fundamental principle that sent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices.				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		review, and clinical failed to follow phys	record review, the facility staff lician orders for 2 of 12 current	in the second	1. Physician was immediately notif		

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

Electronically Signed

08/01/2018

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.

DEDARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2018

		AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		O	<u>ив NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	СОМІ	SURVEY PLETED
	H NINLE IN LINE	495191	B. WING		07/1) 2/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DI AND 6	CONTY MUDONO A	BELLABILITATION CENTER		12185 GRAPEFIELD ROAD		
BLAND (OUNTY NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314		
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 684	Continued From pa	ge 1	F 6	84		
	residents in the sur Resident #48).	vey sample (Resident #10 and		the discrepancy in resident #10's or Received orders to discontinue Clor and monitor blood pressures three	nidine	
	The findings include	ed:		daily.	tiiries	
	ordered parameters	f failed to follow physician's s for Resident #10's blood to administering the		Resident # 48 is currently receiving medications as per physician orders		
	resident's blood pre	essure medication.		Current residents in the center has potential to be affected	ave	
	4/21/17 with the foll	admitted to the facility on owing diagnoses of, but not		3. Licensed nurses in the center wil	ll be	
	disorder, anxiety dis			educated by the Director of Nursing/designee on proper monito	ring of	
	Obstructive Pulmor MDS (Minimum Da	nary Disease. On the quarterly takes table table and the set of th		vital signs in relation to PRN B/P medications. Education will also in	clude	
	(Assessment Refer	ence Date) of 5/4/18 coded		to administer available medications STAT box while awaiting arrival fron		
	Mental Status) of 1	ing a BIMS (Brief Interview for 4 out of a possible score of 15.		pharmacy with new/readmissions a	s well	
		also coded as being totally more staff members for		as notify the physician for alternate if medications are not present in the		
	and file and the control of the cont	hygiene and bathing.		box. Licensed nurses have been educated on the contents of the ST.		
		rmed a review of Resident		box.		
		on 7/10/18. During this r noted a physician order on		4. Director of Nursing/designee will		
	the resident's MAR	(Medication Administration		observe Medication Administration		
		in part, "Clonidine0.1		Records for readmits/admits to the		
		e 1 tablet every 6 hours as ed BP (blood pressure)		5 times weekly to ensure medicatio available and administered. In addi		
		Dias. (diastolic) >90" This		medications are not available for	mon, n	
	order was written o			administration and not in the STAT	box,	
ì	The surveyor review	wed the resident's MAR for the		the physician will be notified. The r	eview	
		ne and July 2018. There was		of the medication administration red	cord	
		documented on the MAR		will include ensuring B/P has been	e-cons	
		s. In the vital signs section of or Resident #10, the surveyor		documented for prn B/P medication	IS.	

6/11/18, and 6/13/18.

noted blood pressure documented for 6/1/18,

5. The results will be reported monthly to

the Quality Assurance Committee for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 22 1000	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	40	495191	B. WING		07/1	; 2/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 2185 GRAPEFIELD ROAD BASTIAN, VA 24314		<u> </u>
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	director of nursing documented finding only meant to take complaining of her take it and if the BF then we are to give. The surveyor notifice the above document 4:50 pm. No further informat surveyor prior to the 2. The facility staff orders for medicating #48. The staff failed (milligrams), Klonosubc (subcutaneous Lactobacillus, Imdumg, and Celexa 10) The clinical record 7/9/18 through 7/12 admitted to the facing finited to acute and with hypercapnia, of tracheostomy, chrodiastolic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia, morbid obdepressive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia, morbid obdepressive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia, morbid obdepressive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia, morbid obdepressive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia, morbid obdepressive disorder atherosclerotic heart failur pulmonary disease diabetic chronic kind hypertensive heart anemia hypertensive hypertensive heart anemia hypertensive hypertensive hypertensive hypertensive hypertensive hypertensive hyperte	pm, the surveyor notified the (DON) of the above gs. The DON stated, "The NP the BP if the patient was BP being up, then we were to P fell along these perimeters the medication." The administrative team of the findings on 7/10/18 at the exit conference on 7/12/18. It is a failed to follow physician on administration for Resident and to administer ASA 81 mg pin 0.5 mg, Lovenox 40 mg s), Levaquin 500 mg, ar 20 mg, Ferrous Sulfate 300	F 684	review and discussion. Once the Committee determines the probler longer exists, audits will be conduct a random basis. Date of Completion-08/10/2018 The CAO/DON will be responsible implementation of the plan of corre	m no cted on	

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CETTIE	C I OTT WEDTONITE	WINDOWN OF TAIOES	¥			71410 140	3. 0300 003 1	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	150 W.C. 540 G. HUNNAYS	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495191	B. WING	i		0.	C 7/10/2018	
		433131	D. 11	200		1 0/	7/12/2018	
NAME OF F	ROVIDER OR SUPPLIER			202 004025	ET ADDRESS, CITY, STATE, ZIP CODE			
BLAND C	S SNISHIN VINIO	REHABILITATION CENTER		12185	GRAPEFIELD ROAD			
DEAND C	OOM THOMOMA	TETABLETATION SERVER		BAST	TIAN, VA 24314			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE	
*				i				
F 684	Continued From pa	ge 3	F	684				
	Resident #48's 14 d	day minimum data set (MDS)						
		ssment reference date) of	24 10	81				
		he resident with a BIMS (brief						
		I status) of 15 out of 15.	80					
		ot have any signs or						
		im or psychosis; the resident						
		days during the week.						
	,	,						
	The surveyor review	wed Resident #48's progress						
	notes from admissi	on through 7/12/18. The						
	progress note writte	en 6/14/18 at 17:00 (5:00 p.m.)						
	read in part, "Medic	ations ordered from						
		ext progress note written						
		. read in part "Spoke with						
1		Re-faxed medication orders					@ @	
!		t." A third progress note dated					Tr.	
:		read in part "Called on-call					8	
		with (name omitted).						
		otify(contracting						
*		nitted) to send residents						
		that it will be quicker than						
		ck-up pharmacy since acy) is opening soon for the						
	. • .	plained to him that we						
		imes and faxed orders and						
		resident's medications."						
	Still Haufft Tecenved	resident's inedications.						
j	The surveyor review	wed the 6/13/18 discharge	\$0 50					
1		eadmission physician's orders.	W					
ii.		cations were ordered:	3 8					
		ng (milligram) 1 tablet p.o. (by						
		day for 5 more tablets-Start					j	
	6/14/18	207						
	" Pulmicort 0.5 m	ng inhalation every 12 hours						
		zers 3 ml (milliliter) inhalation						
	3 times per day	244 5205)					•	
	" Prilosec 20 mg day)-start 6/14/18	1 tablet po bid (twice a						

Robitussin 100 mg po q (every) 6 hours p.r.n.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495191	B. WING		A0000 000	C 1 2/2018	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 684	(whenever necess " Aspirin 81 mg " Coreg 12.5 mg " Celexa 10 mg " Ferrous Sulfat 6/14/18 " Lactobacillus " Lipitor 20 mg 6/14/18 " Lovenox 40 m hours-start 6/14/18 " Pepto-Bismol " Depakote 500 " Mucinex 600 mg " Imdur 20 mg 6/13/18 " Tylenol 650 mg " Loperamide 2 for diarrhea " Mylanta 15 ml " Milk of magne constipation " Percocet 5/32 for pain-start 6/13/" " Chloraseptic s " Klonopin 0.5 mg The surveyor review administration recessed for the surveyor review administration recessed for the surveyor review administration time 448 was not adminiordered Klonopin. Lactobacillus was Review of the Jun	1 tablet po daily-start 6/14/18 g po bid-start 6/14/18 1 tablet po daily-start 6/14/18 1 tablet po daily-start 6/14/18 1 tablet po daily-start 6/14/18 1 tablet po at bedtime-start 1 g subcu (subcutaneous) 24 1 po bid prn 1 mg tablet po bid-start 6/14/18 1 tablet po 3 times a day-start 1 g po q6 hours prn for pain 1 mg po tid (three times a day) 1 po q 8 hours prn for GERD 1 sia 30 ml po daily prn for 1 mg 1 tablet po q 8 hours prn 1 for 5 mg 1 tablet po q 8 hours prn 1 for 5 mg 1 tablet po q 8 hours prn 1 for 5 mg 1 tablet po q 8 hours prn 1 for 5 mg 1 tablet po q 8 hours prn 1 for 5 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 tablet po q 8 hours prn 1 for 6 mg 1 fablet po q 8 hours prn 1 for 6 mg 1 fablet po q 8 hours prn 1 for 6 mg 1 fablet po q 8 hours prn 1 fablet po q 8 hours prn	F 684				

DEDADTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2018

		& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES,	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	F	C
		495191	B. WING		07/12/2018
NAME OF	PROVIDER OR SUPPLIER		*17,000	REET ADDRESS, CITY, STATE, ZIP CODE	50 Epoches (1998)
BLAND (COUNTY NURSING &	REHABILITATION CENTER	2000	2185 GRAPEFIELD ROAD ASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIO
F 684	Continued From pa	ige 5	F 684		¥i
	The June 2018 MA 6/14/18 and the end a day for pneumon received Levaquin every other day for #48 did not received The first dose of Ledocumented on 6/1 Lovenox 40 mg sull 24 hours. The starf for 6/14/18 an "x" h	vas ordered every other day. R had an "x" documented on try on the MAR read "one time is until 6/19/18". Resident #48 every day for 7 doses not 5 doses as ordered. Resident Levaquin beginning 6/14/18. evaquin administered was 5/18. cocutaneous was ordered every t date was 6/14/18. In the box and been placed. Resident #48 enox as ordered every 24	ā		0
	6/14/18, Celexa 10 start 6/14/18, and f ordered once a day in the boxes for 6/1 not administered a The surveyor was	red once a day to start mg ordered once a day to Ferrous Sulfate 300 mg y to start 6/14/18 all had an "x" 4/18. The medications were s ordered. unable to locate the June 2018 stration record for Imdur 20 mg	•		
	nursing (DON) and nursing (ADON) or DON stated that m from the pharmacy physically in the bu discharge summar dots beside the me been placed on the surveyor reviewed	viewed both the director of I the assistant director of 17/12/18 at 10:46 a.m. The edications couldn't be ordered vantil the resident was silding. The DON reviewed the y from the hospital and stated edications indicated they had a MAR. The DON and the June 2018 MARs together. 81 mg and Lactobacillus were			er en

"over the counter" medications and Levaquin 500

PRINTED: 09/12/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	70 00	LE CONSTRUCTION		E SURVEY IPLETED
			7. BOILDING		С	
		495191	B. WING		07/12/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		NAMES OF STREET
BLAND (COUNTY NURSING &	REHABILITATION CENTER	i	12185 GRAPEFIELD ROAD		
				BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	mg was in the stat to those medications of DON stated the ord was not in the stat to unable to locate payscheduled medications. To provide evidence the Imdure 20 mg tide begated the missing of containing the Imdurector of nursing, nursing, and the reliasues with medical Resident #48 as ord No further information exit on 7/12/18. Tube Feeding Mgm CFR(s): 483.25(g)(4)-(5) E (Includes naso-gast both percutaneous percutaneous endo enteral fluids). Base comprehensive assensure that a reside \$483.25(g)(4) A reseat enough alone of enteral methods un condition demonstrations.	oox and did not know why were not administered. The lered dose of Lovenox (40mg) oox. The DON stated she was ge 1 of the June 2018 ons and page 1 of the June he DON was unable to be facility staff administered ginning 6/13/18. The DON MAR was probably the page of administration. The defined administrator, the state assistant director of the above stions not administered to dered on 7/12/18 at 1:15 p.m. The defined prior to the strict and gastrostomy tubes, endoscopic gastrostomy and secopic jejunostomy, and end on a resident's sessment, the facility must	F 693			8/10/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2018 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED	
	495191	B. WING		10000110600	C /12/2018	
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		IZZUIU	
BLAND COUNTY NURSING &	DEHARII ITATION CENTER		12185 GRAPEFIELD ROAD			
DEATH COURT I TOTAL	REMADILITATION CERT LIT		BASTIAN, VA 24314			
PRÉFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	.D BE	(X5) COMPLETION DATE	
F 693 Continued From pa	vao 7	FC	22	1000000		
		F 69	93			
	sident who is fed by enteral					
	e appropriate treatment and if possible, oral eating skills	M.				
	ir possible, oral eating skills iplications of enteral feeding	1				
	nited to aspiration pneumonia,					
	dehydration, metabolic					
	nasal-pharyngeal ulcers.					
	NT is not met as evidenced					
by:	T T TO MAINTAIN TO SOLUTION CONTRIBUTION OF THE PARTY OF					
	tion, staff interview, and clinical		F693			
record review, the fa	acility staff failed to ensure 1		. 545			
of 12 current reside	ents (Resident #23) was		1. Resident #23 is currently not a r	resident		
assessed by the reg	gistered dietician (RD) for		in the center.			
weight loss. Reside	ent #23 had continuous tube					
feeding.			2. A review of resident's receiving	tube	S.	
21		ii .	feedings in the center was conduc	ted to	į	
The findings include	∍d:		ensure those with significant weigh	ht loss		
The feeling OD felle	5 31-120		for the last 60 days had a RD cons	sult		
I ne facility HD faller	d to assess Resident #23		completed timely.			
When the resident in	ad a significant weight change		T T. I T.			
III 30 days or 0.14 /o 4/26/19 to 5/24/19	, which is 9.6 pounds from	ri .	3. Chief Administrative Officer/desi			
dropped from 166 to	Resident #23's weight 0 156.4 pounds in 1 month.		will educate the Registered Dietitia			
Resident #23 is NP	O (nothing by mouth) and was	in the second se	the importance of timely assessme	ent of		
fed by a PEG (perci	o (nothing by mouth) and was a utaneous endoscopic		resident receiving tube feedings	1.2	ļ	
gastrostomy) tube c			experiencing significant weight los		ļ	
9444,, 122.	Ontinuousiy.		addition, CDM will maintain Regist Dietitian referral log to ensure all re		ļ	
The clinical record of	of Resident #23 was reviewed	8	are followed up with timely.	errais		
	/18. Resident #23 was	Å	are rollowed up with differy.			
admitted to the facili	ity 1/19/18. The resident has		4. Director of Nursing/designee wil	П		
	alizations since admission the		monitor RD visits weekly to ensure			
most recent re-admi	ission being 6/25/18.		consults for residents with tube fee			
Resident #23 diagno	oses included but were not		and with significant weight loss have			
limited to acute and	chronic respiratory failure,		completed timely.		2	
dependence on rest	pirator, type 2 diabetes		•	9	1	
mellitus, hereditary s	spastic paraplegia, asthma,		The results will be reported mon	ithly to	89	
fibromyalgia, major o	depressive disorder, anxiety		the Quality Assurance Committee f	for		
disorder, right wrist a	and right hand contracture,		review and discussion. Once the Q	Aς		

tracheostomy, chronic obstructive pulmonary

review and discussion. Once the QA

Committee determines the problem no

OLIVIE	IO I OIT WILDIOAITE	A MEDIOAID SETTIOES			OND NO. 0330-0331
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	26 (9846) 900000	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495191	B. WING	i	C 07/12/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DI AND C	COUNTY NUBERIC C	DELIABILITATION CENTED		12185 GRAPEFIELD ROAD	
BLAND	JOUNTY NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETION
F 693	Continued From pa	na 8		693	
1 000		e uropathy and functional	F 5	Secretar BASS	hiotod on
	quadriplegia.	e dropathy and functional		longer exists, audits will be cond a random basis.	lucted on
	(MDS) assessment reference date (ARI resident with a BIM status) of 12 out of Swallowing/Nutrition Section K0510 Nutrimarked for Feeding Taken by Artificial Finesident #23 receiving calories through pathe 7 day look back centimeters) day or by IV or tube feeding Current comprehentidentified the reside and interventions in (registered dietician)	nal Status and specifically ritional Approaches was Tube only. K0710. Percent doute was marked that yed 51% or more of total renteral or tube feeding during period and 501 cc(cubic more of fluid intake per day g.		The CAO/DON will be responsible implementation of the plan of co	
	5:15 p.m. The resid	ved Resident #23 on 7/9/18 at dent was in bed with the head and receiving Glucerna 1.2 at			
		wed Resident #23's weights	! !		Î
	since admission.	Hoolaalii iilaa a walgiita			
	1/20/18=160 2/11/18=166.1				8
	2/13/18=162.6				100 No.
	2/22/18=166.4		n B		
	3/1/18=161.2				~
	3/5/18=161.8				5
	3/22/18=165		D) 50 50		Ī.
	3/29/18=168 4/5/18=166		i I		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NO. AND ADMINISTRATION OF THE RESERVE OF THE RESERV	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	1000000
		495191	B. WING		C 07/12/2018	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE COMPLETI	ON
F 693	"Quarterly note: R vent/trach depende her nutrition and hy current weight (2-1 (height) 65 inches, range) is 113-137 l 25.96. She has ha in 30 days of 6.149 her to the RD due intact. She is rece receives supplementated and a mu. The surveyor informursing of the weight recommendation be inability to locate the clinical record on 7	ated 5/24/18 4:37 p.m. read esident #23 continues ent. She is NPO. She receives adration via PEG tube. Her 3-18) is 156.4 lbs. (pounds), ht IBWR (ideal body weight bs., BMI (body mass index) is d a significant weight change 6 which is 9.6 lbs. Referring to weight loss. Her skin is iving diuretic therapy. She ints of lactobacillus, potassium	F 6	93		
	surveyor 7/12/18 a was not completed. The surveyor was assessment and rerecord and intervie services on 7/12/18 asked the director process for informit DCS stated the RE	t 12:12 p.m. that an RD consult			it it is a second of the secon	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X				X3) DATE SURVEY COMPLETED	
						ĺ	С	
		495191	B. WING _		(A-1)	07/	/12/2018	
246/2014/00/00/00/00/00/00/00/00/00/00/00/00/00	NAME OF PROVIDER OR SUPPLIER BLAND COUNTY NURSING & REHABILITATION CENTER			12185	ET ADDRESS, CITY, STATE, ZIP CODE GGRAPEFIELD ROAD FIAN, VA 24314			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ī	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CORRECT)	D BE	(X5) COMPLETION DATE	
F 693	gives the RD the int tell her that there is review.	formation and texts the RD to information for the RD to	F 69	93				
	director of nursing, nursing, and the rel	ned the administrator, the the assistant director of hab manager of the above of the survey meeting on						
	exit conference on	ocedures/Pharmacist/Records	F 75	55			8/10/18	
	drugs and biologica them under an agre §483.70(g). The fa- personnel to admin	Services ovide routine and emergency ls to its residents, or obtain ement described in cility may permit unlicensed ister drugs if State law ider the general supervision of					The control of the co	
	pharmaceutical sen that assure the acc dispensing, and adi	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.						
		Consultation. The facility ain the services of a licensed						
11111		des consultation on all ision of pharmacy services in						

PRINTED: 09/12/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	HS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2002 2000 ASSO 200 ASSO	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495191	B. WING		C 07/12/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				12185 GRAPEFIELD ROAD		
BLAND (COUNTY NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLÉTION	
F 755	Continued From pa	ge 11	E 7	755		
F 755	§483.45(b)(2) Estal	olishes a system of records of ion of all controlled drugs in	F 7	55	di Generali	
	order and that an a is maintained and p This REQUIREMEN by: Based on staff inte and clinical record to ensure physician	rmines that drug records are in account of all controlled drugs periodically reconciled. No is not met as evidenced rview, facility document review review, the facility staff failed ordered medications were a residents (Resident #48).		F755 1. Resident # 48 is currently receiv medications as per physician order		
	The findings include	e d :	and the second	Current residents in the center h potential to be affected	iave	
	ordered medication administration for R was readmitted fror facility staff failed to medications were a Klonopin 0.5 mg (m	ed to ensure physician s were available for esident #48. Resident #48 in the hospital on 6/13/18. The ensure the following vailable for administration: illigrams), Lovenox 40 mg/0.4 20 mg and Ferrous Sulfate		3. Licensed nurses in the center wieducated by the Director of Nursing/designee to administer avainedications from STAT box while a arrival from pharmacy with new/readmissions as well as notify physician for alternate orders if medications are not present in the box. Licensed nurses have been	ailable awaiting the	
	7/9/18 through 7/12 admitted to the facil 6/13/18 with diagno limited to acute and with hypercapnia, d tracheostomy, chro diastolic heart failur pulmonary disease, diabetic chronic kid	of Resident #48 was reviewed /18. Resident #48 was ity 5/15/18 and readmitted ses that included but not chronic respiratory failure ependence on respirator, nic combined systolic and e, chronic obstructive type 2 diabetes mellitus with ney disease, diverticulosis, disease, iron deficiency		educated on the contents of the ST box. 4. Director of Nursing/designee will observe Medication Administration Records for readmits/admits to the 5 times weekly to ensure medication available and administered. In add medications are not available for administration and not in the STAT the physician will be notified.	center ons are lition, if	

anemia, morbid obesity, hyperlipidemia, major

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495191	B. WING	· · · · · · · · · · · · · · · · · · ·	С	
NAME OF I	PROVIDER OR SUPPLIER	430131	1	STREET ADDRESS, CITY, STATE, ZIP CODE	07/12/2018	
MANUE OF I	HOVIDEN ON SUFFEIEN					
BLAND (COUNTY NURSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD		
				BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 755	Continued From pa	ge 12	F 75	55	2 27 28	
	atherosclerotic hea gastro-esophageal Resident #48's 14 o	r, generalized anxiety, rt disease, pneumonia, and reflux disease (GERD). day minimum data set (MDS)		5. The results will be reported mon the Quality Assurance Committee for review and discussion. Once the Quality Committee determines the problem longer exists, audits will be conducted.	or A n no	
	with an ARD (asses	sment reference date) of		a random basis.	powers.muserman	
		ne resident with a BIMS (brief			500	
		status) of 15 out of 15.		CAO/DON will be responsible for	Law	
		ot have any signs or		implementation of the plan of corre	ction.	
		m or psychosis; the resident days during the week.		1		
	The surveyor review	ved Resident #48's progress				
		on through 7/12/18. The			ij.	
		en 6/14/18 at 17:00 (5:00 p.m.)			j	
İ		ations ordered from		1	Ĭ	
		xt progress note written	I.		1	
į		. read in part "Spoke with		9		
į.		Re-faxed medication orders		#		
á		." A third progress note dated				
3		read in part "Called on-call			2	
1		vith (name omitted).	6	2 2	1	
	ne stated ne will no	tify(contracting nitted) to send residents			Ĭ.	
Î	modications STAT t	hat it will be quicker than	6	I ·		
	requesting from had	ck-up pharmacy since		8		
		acy) is opening soon for the		ъ		
		lained to him that we			g)	
		mes and faxed orders and			W W	
į	still hadn't received	resident's medications."				
	Tello					
		ved the 6/13/18 discharge		N at		
		eadmission physician's orders. cations were ordered:		97 10		
		cations were ordered: ng (milligram) 1 tablet p.o. (by				
		day for 5 more tablets-Start		N .	##	
	6/14/18	day for a more tablets-staft			r I	
Į.		g inhalation every 12 hours			#	
	" DuoNeb nebuliz	zers 3 ml (milliliter) inhalation				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	**		Greet Taylor and Salary	5000 98001		c	
		495191	B. WING			07/12/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
BLAND (COUNTY NURSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD			
				BASTIAN, VA 24314		200000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From no	00.13					
F 733	Continued From pa	ge 13	F 7	55			
	3 times per day	1 tablet no bid (twice a					
	day)-start 6/14/18	1 tablet po bid (twice a		æ			
		mg po q (every) 6 hours p.r.n.		B .			
	(whenever necessa			a a			
		tablet po daily-start 6/14/18				*	
, i		po bid-start 6/14/18					
		tablet po daily-start 6/14/18				!	
8		300 mg 1 tablet po daily-start				į	
	6/14/18 ·						
	Lacionacinus	capsule po daily-start 6/14/18				II ii ii	
	6/14/18	tablet po at bedtime-start				# #	
		subcu (subcutaneous) 24					
	hours-start 6/14/18					×	
	" Pepto-Bismol p	o bid prn				# E	
		ng tablet po bid-start 6/14/18		å 8			
		g po bid-start 6/14/18		31		**************************************	
		tablet po 3 times a day-start		€			
	6/13/18			8			
		po q6 hours prn for pain		v			
	for diarrhea	ng po tid (three times a day)					
		oo q 8 hours prn for GERD				Ì	
		ia 30 ml po daily prn for					
	constipation						
		mg 1 tablet po q 8 hours prn		£		-	
	for pain-start 6/13/1			11 11			
	" Chloraseptic sp			9.			
,	Klonopin 0.5 mg	g q 6 hours-start date 6/13/18					
	The surveyor review	ved the June 2018 medication					
		ds. Klonopin 0.5 mg ordered					
	q 6 hours was not q	iven as ordered 6/13/18 at					
į	2200 (10:00 p.m.),	6/14/18 at 0500, 1200, 5:00		76			
	p.m. or 10:00 p.m.)	and 6/15/18 at 0500, 1200,		- 10		į	
		p.m. In each box for the		r.		Ñ	
Į.		there was an "x". Klonopin be administered to Resident					

<u> </u>	TO TOTT WED TO THE	WINEDIOMID DELITIOED			OND 140. 0330-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495191	B. WING		С
	<u> </u>	493191	D. WING		07/12/2018
	PROVIDER OR SUPPLIER COUNTY NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 755	Continued From pa #48 for nine doses.		F 7	55	
	24 hours. The stant for 6/14/18 an "x" h not available for ad on 6/14/18 0500. Ferrous Sulfate 300 to start 6/14/18 and 6/14/18 at 0500.	ocutaneous was ordered every to date was 6/14/18. In the box ad been placed. Lovenox was ministration to Resident #48 O mg was ordered once a day had an "x" in the box for the medication was not stration as ordered.			
		tration record for Imdur 20 mg	958		
	nursing (DON) and nursing (ADON) on DON stated that me from the pharmacy physically in the buildischarge summary dots beside the medical been placed on the surveyor reviewed to the DON stated the (40mg) was not in the scheduled medication prince medications. To provide evidence the limitary 20 mg tid beginted the missing frontaining the limitary of	iewed both the director of the assistant director of 7/12/18 at 10:46 a.m. The edications couldn't be ordered until the resident was lding. The DON reviewed the from the hospital and stated dications indicated they had MAR. The DON and he June 2018 MARs together. The ordered dose of Lovenox he stat box. The DON stated locate page 1 of the June 2018 lons and page 1 of the June he DON was unable to e facility staff administered ginning 6/13/18. The DON MAR was probably the page or administration.			
		rector of nursing on 7/12/18 at			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	9 M				OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495191	B. WING	i		07	C 7/ 12/2018	
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	E		
		power the result of the		1218	5 GRAPEFIELD ROAD			
BLAND C	COUNTY NURSING &	REHABILITATION CENTER		BAS	TIAN, VA 24314			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 755	administration. The pharmacy routine rep.m. and 9:00 p.m. by noon. The second The cut off time for p.m. The DON state orders are placed in the orders are autopharmacy. The DOD back-up pharmacy there was not a lock however, the contrapharmacy probably surveyor requested Klonopin. The pharmacy information of the surveyor information.	ications not available for a DON stated the regular un (first run) was between 8:00 if the medications are ordered and run was around 3:00 a.m. that run (delivery) was 4:00 ted once the medication in to Point, Click, Care (PCC), matically sent to the DN was asked where the was located. The DON stated al back up pharmacy; acted pharmacy's back-up or comes from Richmond. The difference that the pharmacy manifest for rmacy manifest was reviewed. The difference delivered 6/15/18.	F	755				
	nursing, and the reissues with medica administration to Rp.m. The surveyor obtaining medicatic contracted pharma. The surveyor review Medication Shortagon 7/12/18. "Proceedings of the surveyor review Medication Shortagon 7/12/18."	the assistant director of hab manager of the above ations not available for resident #48 on 7/12/18 at 1:15 requested the facility policy on ons from the facility's acy. wed the facility policy titled "7.0 ges/Unavailable Medications" edure: 1. Upon discovery that equate supply of a medication						
	to administer to a immediately initiate medication from pl shortage is discovered administration, fac	resident, facility staff should be action to obtain the harmacy. If the medication ered at the time of medication ility staff should immediately ecified in Sections 2 or 3 of this					1	

Policy 7.0, as applicable.

OLIVILI	13 TOR WILDICANE	A WIEDICAID SERVICES			Olvid	NO. 0936-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
_50000490 2V		495191	B. WING			C 07/12/2018		
NAME OF	PROVIDER OR SUPPLIER	in the		STREET ADDRESS, CITY, STATE	ZIP CODE			
DI AND C	OUNTY AUTOMIO A	DELIA DILITATIONI GENTED		12185 GRAPEFIELD ROAD				
BLAND	JUUNIY NUHSING &	REHABILITATION CENTER		BASTIAN, VA 24314				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIAT			
F 755	Continued From pa	ge 16	F 7	755		3		
	2. If a medication s	shortage is discovered during	Tr.					
		ours: 2.1 Facility nurse	6 6 1					
		cy to determine the status of						
		edication has not been	31					
		ed facility nurse should place	E E					
·		r for the next scheduled next available delivery causes	ve eu					
		lose in the resident's		i				
		le, facility nurse should obtain	į	8				
		the Emergency Medication						
,		er the dose. 2.3 If the	ĺ			9		
		vailable in the Emergency						
,		facility staff should notify						
	pharmacy and arra	nge for an emergency delivery.	ĺ					
	2 If a madiantian s	bortons in discovered effect						
		shortage is discovered after ours: 3.1 A licensed facility						
		the ordered medication from		1				
		dication Supply. 3.2 If the				ĺ		
		is not available in the						
		tion Supply, the licensed						
		all pharmacy's emergency						
;		and request to speak with the	16 Ed	v.				
	to the state of th	ist on duty to manage the plan		Î				
	of action. Action m							
,	3.2.1 Emergency de							
	pharmacy.	ergency (back-up) third party				1		
	pharmacy.							
	4. If an emergency	delivery is unavailable, facility						
		ct the attending physician to						
n	obtain orders or dire		,					
1	W							
		on was provided prior to the	1					
E 750	exit on 7/12/18.	and the second of the second o	-	uro:		64646		
	CFR(s): 483.45(c)(3	sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 7	58		8/10/18		

CENTER OF MEDICALE & MEDICALE CENTROLS		I WILDIONID SETTIOLS	· · · · · · · · · · · · · · · · · · ·			ONID 110: 0300 0031	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		(X3) DATE SURVEY COMPLETED		
		495191	B. WING	B		07	C / 12/2018
NAME OF 6	DOWNER OF BURBLER		TO THE PERSON NAMED IN COLUMN	CTO	SET ADDRESS OFTE PLATE TIP CODE	1 07	712010
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BLAND (COUNTY NURSING &	REHABILITATION CENTER		1	85 GRAPEFIELD ROAD STIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	affects brain activition processes and behout are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compressident, the facility §483.45(e)(1) Resi	tropic Drugs. ychotropic drug is any drug tha ies associated with mental avior. These drugs include, to, drugs in the following		758			
	unless the medicat specific condition a in the clinical recore §483.45(e)(2) Resi drugs receive grade	ion is necessary to treat a is diagnosed and documented d; dents who use psychotropic ual dose reductions, and	6 0 1	9			
		tions, unless clinically an effort to discontinue these					
	psychotropic drugs unless that medica	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and					·
	are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the	l orders for psychotropic drugs lys. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their	я s				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
*			n. Bolzbire		С	
		495191	B. WING		07/12/2018	
	PROVIDER OR SUPPLIER COUNTY NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 758	§483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriatenes. This REQUIREME by: Based on staff intereview, the facility residents were free (Resident #18, Resident #23, and The findings includ 1. The facility staff monitoring for the particular Celexa for Resident #18 was with diagnoses that acute and chronic myocardial infarctic pulmonary disease status, gastrostom disorder, major del hyperlipidemia, insignstro-esophageal. The OBRA minimulassessment refere assessed the residinterview for mentasigns of delirium of described as feeling in the staff of the sta	ident's medical record and on for the PRN order. I orders for anti-psychotic of 14 days and cannot be extending physician or oner evaluates the resident for sof that medication. Note in the interest of intere	F 758	F758 1. Residents #18, #48, #3, & #29, currently having behaviors monitore every shift. Resident #23 is currently not a resident in the center. 2. Current facility residents receivin psychotropic medications have pote to be affected. 3. Licensed nurses will be educated the Director of Nursing/designee on initiating behavior/side effect monitor the time of admission if the resident prescribed psychotropic medication Education will also include ensuring behavior/side effect flow sheets are completed every shift. 4. Director of Nursing/designee to monitor behavior monitoring/side efflow sheets 5 times weekly to ensuring timely initiation and completeness. 5. The results will be reported monitor Quality Assurance Committee for review and discussion. Once the QV Committee determines the problem longer exists, audits will be conduct a random basis.	ed og ential d by oring at is s. fects re thly to or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES	Was as		ľ	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	COM	E SURVEY MPLETED
1700		495191	B. WING			C / 12/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BI AND C	OUNTY NUBSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD		
DEAND C	OOM THOUSING W	TETABLETATION OF THE		BASTIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE (CROSS-REFERENCE))	BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 19	F 7	58		
, , , ,	Resident #18's curr initiated 4/6/16 for u medications and re interventions to be side effects of med decrease/elimination	rent comprehensive care plan use of psychotropic vised 3/15/2018 identified evaluate effectiveness and ications for possible on of psychotropic drugs per Observe for adverse effects		CAO/DON will be responsible for implementation of the plan of corre	ection.	
	(milligrams) every o Physician's Desk R	orders for Celexa 20 mg day. According to the leference, escitalopram is an d for the treatment of		•		
	and side effects flor April 2018 side effe	wed the behavior monitoring w sheets for April 2018. The ect monthly flow sheet did not ffect was being monitored.				2
	not have evidence #18 was monitored through 5/17/18 an evening/night shift: 5/11/18, 5/14/18, 5/ 2018 Side Effects N have evidence of m 5/1/18 through 5/31	avior Monthly Flow Sheet did that the behavior for Resident on the day shift 5/1/18 d on the following 5/1/18 through 5/3/18, 5/6/18, /17/18, and 5/18/18. The May Monthly Flow Sheet did not nonitoring on the day shift 1/18 and the evening/night shift 18, 5/6/18, 5/11/18, 5/13/18,	ν			
	8.53	unable to locate the June 2018 Flow Sheet or the Side Effects				

The surveyor informed the assistant director of nursing of the above concern on 7/12/18 at 9:06

OLIVILI	13 I OH WEDICANE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495191	B. WING		C 07/12/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 100 100 100 100 100 100 100 100 100 1
BLAND (COUNTY NURSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD BASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
F 758	monitoring for April DON stated the fac	onfirmed the incomplete 2018 and May 2018. The ility was unable to locate the r Monthly Flow Sheets and the	F7	758	
	was reviewed. On pharmacist had doo behavior monitoring to be maintained countries the following items:	medication regimen review the note, the contracting cumented Resident #18's documentation appears not empletely; that is, it is missing 1. Behavior monitoring for opram and Clonazepam.			
	director of nursing,	ned the administrator, the the assistant director of ab manager on 7/12/18 at		No.	e e
	No further informati exit conference on	on was provided prior to the 7/12/18.			
		failed to provide behavior dent #48's psychotropic and Clonazepam.		<u>1</u>	ā v
	7/9/18 through 7/12 admitted to the facil 6/13/18 with diagno limited to acute and with hypercapnia, d tracheostomy, chroidiastolic heart failur pulmonary disease, diabetic chronic kidi hypertensive heart canemia, morbid obe	of Resident #48 was reviewed /18. Resident #48 was ity 5/15/18 and readmitted ses that included but not chronic respiratory failure ependence on respirator, nic combined systolic and e, chronic obstructive type 2 diabetes mellitus with ney disease, diverticulosis, disease, iron deficiency esity, hyperlipidemia, major y generalized anxiety,			

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CENTER	15 FUR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>MR MO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495191	B. WING	A CONTRACTOR AND CONT			C /12/2018
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		Wester .
			İ	1218	5 GRAPEFIELD ROAD		
BLAND C	OUNTY NURSING &	REHABILITATION CENTER		BAS	TIAN, VA 24314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	ne 21	F 7	58 58			
	76.57	rt disease, pneumonia, and		Ju			l
		reflux disease (GERD).					
	with an ARD (asses 6/27/18 assessed the interview for mental Resident #48 did not symptoms of deliriud did reject care 4-6 cointerview identified hopeless and feeling severity score=6. Resident #48's currinitiated 6/1/18 identifor adverse effects	day minimum data set (MDS) asment reference date) of the resident with a BIMS (brief I status) of 15 out of 15. The thave any signs or the resident days during the week. Mood feeling down, depressed or the days during the week. Mood feeling down, depressed or the days during the week. Total the resident was at risk related to psychotropic dary to dx (diagnosis) of					
		ohysician orders for Celexa 10 nning 5/301/8 and Klonopin 0.5 a day) for anxiety.	ਜ਼	80			
	Celexa (citalopram)	nysician's Desk reference,) is an antidepressant in a ed selective serotonin reuptake	:: :::::::::::::::::::::::::::::::::::	80			X Y
	Klonopin is an Oral benzodiazepine, not treatment of absence (Lennox-Gastaut sy myoclonic seizures	ticeable efficacy in the ce, petit mal variant (ndrome), and akinetic and but ineffective for tonic-clonic d for panic disorder and					

The surveyor reviewed the clinical record for the

CENTER	13 FOR MEDICARE	& MEDICAID SERVICES			OND NO. 0536-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	201 10202 1944022300	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495191	B. WING		07/12/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE	OULD BE COMPLETION
F 758	the Side Effects Flounable to locate an 2018. The surveyor records staff (MR#The surveyor review Monitoring Flow Sheet. The Behavithe Side Effects Flocompleted upon Rethe facility 6/13/18.	ge 22 Monitoring Flow Sheets and by Sheet. The surveyor was y behavior monitoring for May r informed the medical I) on 7/12/18 at 11:07 a.m. wed the June 2018 Behavior eets and the Side Effects Flow or Monitoring Flow Sheets and by Sheet had not been esident #48's readmission to Medical records #1 stated he is May or June 2018 behavior	F 7	758	
	director of nursing, nursing and the reh 1:15 p.m. No further informati	ned the administrator, the the assistant director of tab manager on 7/12/18 at ton was provided prior to the		*	
	monitoring for Resimedications Vistarial The clinical record of 7/9/18 through 7/12 admitted to the faci included but not limit failure, atherosclerodiabetes mellitus, p	failed to provide behavior dent #3's psychotropic I, Wellbutrin SR, and Ativan. of Resident #3 was reviewed 1/18. Resident #3 was lity 7/27/15 with diagnoses that ited to chronic respiratory otic heart disease, type 2 ulmonary hypertension, onea, morbid obesity, and			
	assessment with ar (ARD) of 6/28/18 as	erly minimum data set (MDS) n assessment reference date ssessed the resident with a w for mental status) as 15 out			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20001 300490700000000		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495191	B. WING	004	4 1898.	07	C //12/2018	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
		CARCOLL SECTION OF THE CONTRACTOR AND ADDRESS OF THE CONTRACTOR AND ADDRESS OF THE CONTRACTOR AND ADDRESS OF THE CONTRACTOR ADDRESS OF THE CONTRACTO		1218	5 GRAPEFIELD ROAD			
BLAND C	OUNTY NURSING &	REHABILITATION CENTER		BAS	STIAN, VA 24314			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 758	Continued From pa	age 23	F 7	58			i.	
	And Annual Manager Control of the Co	symptoms of delirium or		AF (15)]	
		nterview revealed the resident						
		depressed or hopeless, had						
		aying asleep, and feeling tired						
	or having little energy.		:					
							0,0	
	Current comprehensive care plan initiated 7/27/15 and reviewed 7/10/18 identified Resident							
	#3 required use of psychotropic medications with							
		se reactions related to						
		xiety. Resident #3 is on Ativan						
	and Wellbutrin.		ĺ	e				
		hysician orders for Ativan 0.5						
		time and Wellbutrin SR						
) 150 mg every day.		21				
		ion) is an antidepressant treat major depressive						
		onal affective disorder.						
		belongs to a group of drugs					5	
		oines . Lorazepam affects						
		ain that may be unbalanced in					8)	
		. Ativan is used to treat anxiety					an an	
	disorders.						8	
	The surveyor revie	wed the May 2018 behavior						
		and found no monitoring	6				į.	
		/18 evening/night shift for	I.	2			1	
	Ativan, Vistaril and	Wellbutrin. The May 2018	80	15				
		Sheet did not specify the side						
		monitor and failed to	Ţ.					
	document on 5/15/	18 evening/night shift.						
	The surveyor revie	wed the June 2018 behavior						
		and found no monitoring						
		/18 evening/night shift for						
	Ativan and Wellbut							

The surveyor informed the assistant director of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495191	B. WING _		C 07/12/2018
NAME OF PROVIDER OR SUPPLIER BLAND COUNTY NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12185 GRAPEFIELD ROAD BASTIAN, VA 24314	1 07/12/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
F 758	the ADON stated, " The surveyor information director of nursing, nursing, and the resistant to the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the properties of the facility staff monitoring for the facility staff moni	at 11:31 a.m. After reviewing, it was a night shift nurse." med the administrator, the the assistant director of hab manager on 7/12/18 at ion was provided prior to the	F 75		
	Resident #23's qua (MDS) assessment reference date (AR resident with a BIM status) of 12 out of symptoms of delirio interview revealed I	rterly minimum data set with an assessment D) of 5/24/18 assessed the S (brief interview for mental 15. There were no signs or m or psychosis. Mood Resident #23 had feelings of seed or hopeless and feeling energy.			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				ОМ	B NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUING	UCTION	(X	(3) DATE SURVEY COMPLETED
		495191	B. WING	The state of the s			C 07/12/2018
//////////////////////////////////////	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•		DRESS, CITY, STATE, ZIF PEFIELD ROAD VA 24314	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTI SS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 758	initiated 1/31/18 an resident had behave agitated, crying, refinating negative states at risk for adverse of psychotropic diagnosis of anxiety. Interventions included effects of medidecrease/elimination pharmacy recommerciated to antipsych. Resident #23's phy 100 mg (milligrams times a day. According to the Prizoloft is a medicine reuptake inhibitor (idepressive disorded disorder, panic disorder, panic disordersive states and persident medicine reuptake inhibitor (idepressive disorded disorder, panic disorder).	rent comprehensive care plan d revised 3/5/18 read that the iors of becoming easily using showers or therapy and atements. Resident #23 also erse consequences related to emedications secondary to y and depression. Ided evaluate effectiveness and ications for possible on of psychotropic drugs per endation. Monitor behaviors notic use. Issician's orders included Zoloft of and Klonopin 0.5 mg three ends a selective serotonin SSRI). It is used to treat major r, obsessive compulsive order, post-traumatic stress rual dysphoric disorder, and	F 7	758			
	Klonopin is an Oral benzodiazepine,no treatment of absen (Lennox-Gastaut s myoclonic seizures	ticeable efficacy in the ce, petit mal variant yndrome), and akinetic and , but ineffective for tonic-clonic d for panic disorder and		1. 3s			
		wed the June 2018 Behavior neets and the June 2018 Side					

Effects Flow Sheets. The surveyor was unable to

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
		495191	B. WING		Marie Carlo	07	C //12/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		121	REET ADDRESS, CITY, STATE, ZIP CODE 85 GRAPEFIELD ROAD STIAN, VA 24314	JA 1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Klonopin after the refacility 6/25/18. The surveyor inform	nge 26 18 flow sheets for Zoloft and esident was readmitted to the ned the administrator, the the assistant director of	F 7	758			
į	nursing, and the reh 1:15 p.m. No further informati exit conference on 5. The facility staff	on was provided prior to the 7/12/18.		31			£
	3/15/16 with the foll- limited to anemia, h failure, depression a Pulmonary Disease	eadmitted to the facility on owing diagnoses of, but not high blood pressure, heart and Chronic Obstructive On the quarterly MDS with an ARD (Assessment		81 83			(2)
	Reference Date) of having a BIMS (Brie score of 15 out of a Resident #29 was a extensive assistanc dressing and person	4/23/18 coded the resident as ef Interview for Mental Status) possible score of 15. also coded as requiring see of 1 staff member for nal hygiene and being totally ff member for bathing.					
	#29's clinical record review, the surveyor Sertraline (Zoloft) tablet by mouth one Fri for depression at	rmed a review of Resident I on 7/12/18. During this r noted a physician order for "100 mg (milligram) Give 1 time a day every Mon, Wed, nd Sertraline 100 mg Give 1					
15	Thu, Sat for depress	time a day every Sun, Tue, sion" This order was given ith a beginning date of					8 8 6

CENTER	19 LOW MEDICANE	A MEDICAID SERVICES			CIVID 110. 0330-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495191	B. WING		C 07/12/2018
NAME OF P	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE	
BLAND C	COUNTY NURSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD	
		CONTRACTOR OF THE CONTRACTOR O		BASTIAN, VA 24314	
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F 758	Continued From pa	ige 27	F 758	.	
	The surveyor also monitoring sheets to month of June 201 documentation for	reviewed the behavioral for Resident #29. For the 8, the surveyor noted the dates of 6/1, 6/2, 6/3 and	, , , ,		
	6/4. The rest of the behavioral monitoring sheet for June was blank with no documentation noted.				
		ed the administrative team of named findings on 7/12/18 at ference room.			
		ion was provided to the e exit conference on 7/12/18.			i
	Laboratory Service CFR(s): 483.50(a)(s	F 770)	8/10/18
	laboratory services residents. The faci and timeliness of the facility proservices, the service requirements for last of this chapter. This REQUIREME by:	facility must provide or obtain to meet the needs of its lity is responsible for the quality		F770	
	review, the facility ordered laboratory	staff failed to obtain a physician test for 1 of 12 current rvey sample (Resident #10).	si	Physician was immediately no culture/sensitivity was not obtained Resident #10. No new orders obtained	ed for
	The findings include	led:		Current center residents have to be affected.	potential
	4/21/17 with the fo limited to high bloc	admitted to the facility on llowing diagnoses of, but not od pressure, diabetes, seizure isorder and Chronic		 Licensed Nurses to be educa the Director of Nursing/designee proper transcription of lab orders requisitions to ensure ordered/ob 	on onto lab

CENTER	13 FUR WEDICARE	A MEDICAID SERVICES			MID NO. 0938-0391
AND BLAN OF CORRECTION INCOME.		22 50	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495191	B. WING _		C 07/12/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VIII TOTOROLOGICO		STACK ANDRESS - STALKS SK - STACK - STANKSTACK		12185 GRAPEFIELD ROAD	
BLAND (COUNTY NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314	
(24) 15	SUMMARY STA	TEMENT OF DEFICIENCIES			NI GERMAN
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 770	Continued From pa	ae 28	F 77	! ?O	509 300
	management on the second secon	nary Disease. On the guarterly		The state of the s	545.5
		ta Set) with an ARD		labs are processed according to or	
		ence Date) of 5/4/18 coded		4. Director of Nursing or Designee	
		ing a BIMS (Brief Interview for		audit lab requisitions 5 times week	
		4 out of a possible score of 15.		ensure proper transcription of physordered labs.	sician
		also coded as being totally		AND AND AND AND AND AND AND AND AND AND	مه راماد،
		more staff members for	Î	The results will be reported mor the Quality Assurance Committee	
,		hygiene and bathing.	ž.	review and discussion. Once the C	101
	dicasing, personal	riygierie and batiling.			
	The surveyor perfor	rmed a review of Resident		Committee determines the problem	
		on 7/10/18. During this		longer exists, audits will be conduct a random basis.	aed on
		r noted the following written in		a fatiuotti basis.	
		ert that was obtained on		CAO/DON will be reapposible for	9
		ig CX (culture)" The		CAO/DON will be responsible for	
		also reviewed and there was		implementation of the plan of corre	CTION.
		ed for 6/24/18 which read in			2
i		order) Obtain UA (urinalysis)	Milking.		Ĩ
		ensitivity in AM" The			
		find the results of the urine			
	C&S in the clinical r	and the results of the unifie			
i	Cos in the clinical r	ecolu.			
į	The survey serve and the	NATALON E MINISTERNAS E			,
8		ed the administrative team of			
		ited findings on 7/10/18 at		정	
	4:50 pm.				
ļ	0-7/11/10 -40:15				
		om, the director of nursing			
		eyor with a copy of the			i
		ich was dated and timed for			
		10 pm) for "UA C&S in am"			
		ing stated, "We didn't get			
	this."				
	No further informati	on was provided to the			
		e exit conference on 7/12/18.			
F 801	Qualified Dietary St.		F 80	01 :	8/10/18
	CFR(s): 483.60(a)(. 50	24 22	0/10/10
, C	§483.60(a) Staffing	X 2 . C			
	3 .00.00(a) otaining				

OLIVIE !	TO TOTT WILD TO THE	Q INCOMO CENTATOEO	-		CIVID IV	C. 0330-0331	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		495191	B. WING		۱ ,	C 7/12/2018	
NAMEOF	SBOVIDED OF CUEBLIER		24 3 3			7112/2016	
	PROVIDER OR SUPPLIER COUNTY NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 12185 GRAPEFIELD ROAD BASTIAN, VA 24314	IDE		
250.05 Protection 1999				No Contraction Contract Contra			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 801	Continued From pa	ge 29	F :	801			
	The facility must en appropriate compet out the functions of taking into consider individual plans of cand diagnoses of thin accordance with required at §483.70	apploy sufficient staff with the tencies and skills sets to carry the food and nutrition service, ration resident assessments, care and the number, acuity ne facility's resident population the facility assessment				47	
	clinically qualified n full-time, part-time, qualified dietitian or nutrition profession. (i) Holds a bachelor a regionally accredi United States (or ar with completion of t a program in nutrition an appropriate nation recognized for this	r's or higher degree granted by ted college or university in the n equivalent foreign degree) he academic requirements of on or dietetics accredited by onal accreditation organization					
	supervised dietetics supervision of a reg professional. (iii) Is licensed or constraint profession services are performant provide for licensur will be deemed to hor she is recognized the Commission on successor organizar requirements of parthis section. (iv) For dietitians him	s practice under the pistered dietitian or nutrition ertified as a dietitian or all by the State in which the med. In a State that does not e or certification, the individual ave met this requirement if he d as a "registered dietitian" by Dietetic Registration or its				7 9 8	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED		
			A. BUILD	ING	80. 0	С
		495191	B. WING	000		07/12/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		121	REET ADDRESS, CITY, STATE, ZIP CODE 85 GRAPEFIELD ROAD STIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 801	Continued From pa	ge 30	. F	301		
	77 1	s after November 28, 2016 or				8
		ualified dietitian or other				12
	employed full-time,	utrition professional is not the facility must designate a the director of food and				
	(i) For designations meets the following years after November year after November	s prior to November 28, 2016, requirements no later than 5 per 28, 2016, or no later than 1 er 28, 2016 for designations	Į			
ž	(C) Has similar nati			1		25
3	certifying body; or D) Has an associat service manageme	e's or higher degree in food nt or in hospitality, if the		1		d
9 9 8 9	management, from higher learning; and	es food service or restaurant an accredited institution of d ve established standards for		1		ä
3 1	meets State require managers or dietar					
	from a qualified die qualified nutrition po					8
į	by:	NT is not met as evidenced ion, staff interview, and clinical		-	F801	j
	record review, the f of 12 current reside assessed by the re-	acility staff failed to ensure 1 nts (Resident #23) was gistered dietician (RD) for ent #23 had continuous tube			1. Resident #23 is currently not a in the center. 2. A review of resident's receiving feedings in the center was conducensure those with significant weights.	g tube cted to

PRINTED: 09/12/2018

		AND HUMAN SERVICES		^	FORM APPROVED
		& MEDICAID SERVICES	Transferrage annual constants		MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495191	B. WING _		C 07/12/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 (01) (22)
DI AND C	POLINITY NUDCING &	DELIABII ITATION CENTED		12185 GRAPEFIELD ROAD	
BLAND (JUNIT NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 801	Continued From pa	ine 31	F 80	1	E .
, 551	The findings include		1 00	for the last 60 days had a RD cons	ault .
	The infalligs include	5 0.		completed timely.	an.
	The facility RD faile	ed to assess Resident #23		Chief Administrative Officer/des	
		nad a significant weight change		will educate the Registered Dietitia	
		s, which is 9.6 pounds from		the importance of timely aasessme	ent of
		Resident #23's weight o 156.4 pounds in 1 month.		residents receiving tube feeding experiencing significant weight loss	s In
		O (nothing by mouth) and was		addition, CDM will maintain Registe	
		utaneous endoscopic		Dietitian referral log to ensure all re	
	gastrostomy) tube o	continuously.		are followed up with timely.	
	* 1	- f D - 1 d - st #00		4. Director of Nursing/designee wi	
		of Resident #23 was reviewed 2/18. Resident #23 was		monitor RD visits weekly to ensure consults for residents with tube fee	
		lity 1/19/18. The resident has		experiencing significant weight loss	
		alizations since admission the		been completed timely.	
	most recent re-adm	nission being 6/25/18.		The results will be reported more	
		ioses included but were not		the Quality Assurance Committee	
		d chronic respiratory failure,		review and discussion. Once the C	
		pirator, type 2 diabetes spastic paraplegia, asthma,		Committee determines the problem longer exists, audits will be conducted	
		depressive disorder, anxiety		a random basis.	.100 011
		and right hand contracture,			
		nic obstructive pulmonary	M	CAO/DON will be responsible for	
	disease, obstructive quadriplegia.	e uropathy and functional		implementation of the plan of corre	ection.
	Desident #00k aug				e E
		rterly minimum data set t with an assessment			
		D) of 5/24/18 assessed the			
	resident with a BIM	S (brief interview for mental			
	status) of 12 out of				
		nal Status and specifically			.
		ritional Approaches was			
		g Tube only. K0710. Percent Route was marked that			er .
		ved 51% or more of total			Î

calories through parenteral or tube feeding during the 7 day look back period and 501 cc(cubic centimeters) day or more of fluid intake per day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495191	B. WING		1	C
		493191	B. WING		07/	/12/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BLAND (COUNTY NURSING &	REHABILITATION CENTER		12185 GRAPEFIELD ROAD		
	oom monoma a	TETABLETATION CENTER		BASTIAN, VA 24314		4
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 801	Continued From pa	ge 32	: F8	01		
	by IV or tube feedir	ıg.		1		
	identified the reside and interventions in (registered dieticiar The surveyor obser 5:15 p.m. The resi	ved Resident #23 on 7/9/18 at dent was in bed with the head				1
	of the bed elevated 55 cc/hr via pump.	and receiving Glucerna 1.2 at		a .		
	The surveyor review since admission. 1/20/18=160 2/11/18=166.1 2/13/18=162.6	wed Resident #23's weights	I i	i		!
	2/22/18=166.4 3/1/18=161.2 3/5/18=161.8 3/22/18=165 3/29/18=168		Ŧ	: : :		
	4/5/18=166 4/26/18=166 5/24/18=156.4 6/19/18=151.2					ī
	6/26/18=153 7/5/18=150.6 7/10/18=150.8			j		# 8
	"Quarterly note: Revent/trach depende her nutrition and hy current weight (2-13 (height) 65 inches, range) is 113-137 lt 25.96. She has had	ted 5/24/18 4:37 p.m. read esident #23 continues nt. She is NPO. She receives dration via PEG tube. Her 3-18) is 156.4 lbs. (pounds), ht IBWR (ideal body weight os., BMI (body mass index) is d a significant weight change which is 9.6 lbs. Referring				i ·

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0							
AND DUAN OF CODDECTION IN IDENTIFICATION NUMBER.			TIPLE CONSTRUCTION ING	(X3)	(X3) DATE SURVEY COMPLETED		
		495191	B. WING			C 07/12/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
Name of the Control o				12185 GRAPEFIELD ROAD			
BLAND (COUNTY NURSING &	REHABILITATION CENTER		BASTIAN, VA 24314			
(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	(X5) COMPLETION E DATE	
F 801	Continued From pa	ge 33	F8	J01			
	her to the RD due to	o weight loss. Her skin is					
	intact. She is receives supplement	ving diuretic therapy. She nts of lactobacillus, potassium		4		ii.	
	chloride, and a mult	tivitamin."					
	nursing of the weigh	ned the assistant director of nt loss concerns, the RD					
		the dietary manager, and the RD recommendations in the 12/18 at 11:00 a.m.	8	77			
20		tor of nursing informed the 12:12 p.m. that an RD consult					
	assessment and re record and interview services on 7/12/18 asked the director of process for informint DCS stated the RD The DCS stated shi gives the RD the info	commendations in the clinical wed the director of culinary at 1:00 p.m. The surveyor of culinary services the ng the RD of a concern. The came to the facility 2x/week. e writes up her findings and formation and texts the RD to information for the RD to				a 8	
	director of nursing, nursing, and the rel	ned the administrator, the the assistant director of nab manager of the above of the survey meeting on				5	
	No further informati exit conference on	ion was provided prior to the 7/12/18.		a.			