PRINTED: 03/28/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	INITIAL COMMENT An unannounced M survey was conduct Corrections are requirements. The survey/report will fol investigated during. The census in this 6 at the time of the su consisted of 12 cur (Residents #1 throu reviews (Residents # 1 throu reviews (Residents # 1 throu reviews (Residents # 1 throu reviews (Resident has the refuse to participate and to formulate an specified in paragra The facility must cor specified in subpart related to maintainin procedures regardin requirements includ provide written infor concerning the right or surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option, formulate an includes a written defined to the surgical treatmen option and the surgical treatmen option are surgical treatment.	ledicare/Medicaid standard ed 2/16/16 through 2/18/16. Lired for compliance with 42 ral Long Term Care Life Safety Code low. One complaint was the survey. O certified bed facility was 56 rvey. The survey sample rent Resident reviews gh #12) and 7 closed record #13 through #19). E; FORMULATE ADVANCE I) In eright to refuse treatment, to in experimental research, advance directive as ph (8) of this section. In of part 489 of this chapter in gwritten policies and ing advance directives. These is provisions to inform and mation to all adult residents to accept or refuse medical than and and the individual's advance directive. This escription of the facility's int advance directives and incomplete in the facility is interesting the survey of the facility is interesting and incomplete in the facility in the facility is interesting and incomplete in the facility in t	F 00	DEFICIENCY)	4/1/16
ABORATORY		R/SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE	(X6) DATE

Electronically Signed 03/11/2016

Facility ID: VA0192

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016
NAME OF PE	ROVIDER OR SUPPLIER	100.00		STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2016
TVAINE OF TH	COVIDER OR OUT LIER				
REGENCY	HEALTH AND REHABIL	LITATION CENTER		112 N CONSTITUTION DR	
				GRAFTON, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 155	Continued From page	e 1	F 158	5	
	by:	is not met as evidenced			
		iew, facility documentation		The statements included are not an	
		d review, and in the course of		admission and do not constitute	
	-	tion, the facility staff failed		agreement with the alleged deficienc	ies
		ident #13) of 19 residents in		herein. The plan of correction is	
		implement the facility "Do		completed in the compliance of state	
	Not Resuscitate" poli	cy.		federal regulations as outlined. To re	
	For Docident #12, the	e facility staff initiated CPR		in compliance with all federal and star regulations the center has taken or w	
		uscitation) even though the		take the actions set forth in the follow	I
		Do Not Resuscitate) order.		plan of correction. The following plan	<u> </u>
	resident flad a Divire	Do Not Neodoonate, order.		corrections constitute the center s	
	Resident #13 was ori	ginally admitted to the facility		allegation of compliance. All alleged	
		nitted after a hospitalization		deficiencies cited have been or will b	e l
		iagnoses of, but not limited		completed by the dates indicated.	
		petes mellitus type II, post		1- Resident #13 was discharged fron	n the
	small bowel obstructi	on with lysis of adhesions,		facility on 10/5/2015	
	and dementia.			2- Unit Manager or Designee will aud	lit
	A closed record revie	w was conducted because		current residents for code status and	
	Resident #13 died on	10/5/15 while at the facility.		ensure that there is a valid DNR order the chart.	er on
	The most Minimum D	ata Set (MDS) was a		3- The Unit Manager or designee will	
	quarterly assessment			educate current licensed nursing stat	
	•	D) of 9/27/15. The MDS		the procedure to follow in validating of	code
		with moderate cognitive		status for residents.	
		endent on staff for bathing;		4-The Unit Manager or designee will	
		ssistance from staff for bed		review residents on a random weekly	
	mobility, transfers, dr	essing, toileting and		basis to ensure that there is a valid D	
	hygiene.			order on the chart. The Unit Manage	I
	0= 0/47/45 -+ 40:00	n ma Danidant #401linital		designee will review any residents w	I
		a.m. Resident #13's clinical		require resuscitation to ensure that the	
		The review revealed a		appropriate measure was taken to fo	
	. ,	"DNR" dated 4/2/15. There		the code status. Results of the audits	
		o Not Resuscitate Order in ned by the physician and		be presented to the quarterly Quality Assurance committee for review and	
		onsible Party on 4/2/15		recommendation.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495189	B. WING				C 18/2016
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER				11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR RAFTON, VA 23692	1 02/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 155	which included the formula of the progress of the progress note where progress note wh	and all qualified health care and art compression, endotracheal advanced airway all ventilation, defibrillation, des) form the patient in the cardiac or respiratory 8 Note dated 8/5/15 included NOT RESUSCITATE." 10 ogress Notes dated 10/5/15 read: 10 sident with agonal ansive with pulse, within desident without respirations and until DNR confirmed" 11 as written by the Director of 12 m.m. an interview was dministrator (Admin-A) and and (Admin-B). When asked desident is a DNR, Admin-B and interview in the computer." When any identifying markers of a order, Admin-B stated "No in the patients or door or any dicy titled "Do Not"		155			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495189	B. WING			1	C 18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 112 N CONSTITUTION DR GRAFTON, VA 23692	, CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
F 157 SS=D	the patient's permane on 2/18/16 at 8:35 a. conducted with Admir was initiated on Residual she "Wasn't sure of cevery person's code of confirmed code status stated she was the firm. The facility staff did not information regarding. COMPLAINT DEFICI NOTIFY OF CHANGI (INJURY/DECLINE/RCFR(s): 483.10(b)(11). A facility must immed consult with the residuance or an interested familial accident involving the injury and has the pointervention; a significantly in existing form of treatments in either life the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a).	tate (DNR) order located on ent medical record." m. an interview was n-B. When asked why CPR dent #13, Admin-B stated ode status, I don't know status." She stated "Once I is I ceased CPR." Admin-B ist responder. ot present any further the findings. ENCY ES COOM, ETC)) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a in, mental, or psychosocial reatening conditions or		157			4/1/16
	The facility must also	promptly notify the resident					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/49/2046
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/18/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 157	or interested family rechange in room or respecified in §483.15 resident rights under regulations as specifithis section. The facility must receive address and pholegal representative. This REQUIREMENT by: Based on staff interview, and clinical refailed to notify the prand/or Responsible condition, for 2 resident the survey sample of the survey sample of the survey sample of the survey sample of the physician of no boccasions in January was ordered, and fair Suppositories which the physician of the facility the responsible eloping from the facility the responsible el	sident's legal representative member when there is a commate assignment as $f(e)(2)$; or a change in Federal or State law or fied in paragraph (b)(1) of ford and periodically update me number of the resident's for interested family member. This not met as evidenced for interested family member. This not met as evidenced for interested family member. This not met as evidenced for interested family member. The interested family member. This not met as evidenced for interested family member. The interested family membe	F 15	1- The order to notify the MD if no BM 48 hours was discontinued for Resider #8 on 3/10/16. Resident #8 is having regular BMs. Resident #17 was discharged from the facility on 9/28/15 2- The Unit Manager or designee will review shift report and orders for curre residents to ensure that the MD and R notified of resident changes in conditio 3- The Unit Manager or designee will educate Licensed nursing staff on notification of MD and RP of resident changes in condition. The Unit Managor designee will educate CNA staff on documentation of resident bowel movements. 4- The Unit Manager or Designee will review shift report and new orders on a random weekly basis to ensure that the RP and MD is appropriately notified of resident changes in condition. Results the audits will be presented to the quarterly Quality Assurance committee review and recommendation.	nt P is on. er a e any of

MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED	
495189	B. WING		C 02/18/2016
ABILITATION CENTER			02/10/2010
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
lizations for small bowel cal impaction. St recent Minimum Data Set int was a quarterly assessment ent Reference Date (ARD) of ident was coded with a Brief cal status (BIMS) score of 3 possible 15 points, indicating impairment. The Resident was no behavior problems, and istance of staff for all activities in the only exception being dired extensive assistance. The coded as always incontinent of r. Subserved on 2-17-16 on bed in the Resident was found to allert, but confused. Resident #8 ed on 2-18-16 at 9:00 a.m. in yes closed. The Resident eand was easily aroused, and talkative, but confused. The Resident was not impaction and and the regimen agents, that were only sician was not made aware el movement in 3-4 days on 2 is ordered, in January & improvided by the DON was	F 15	7	
Tell to the constant of the co	495189	ABILITATION CENTER PY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) Dage 5 Alizations for small bowel cal impaction. St recent Minimum Data Set int was a quarterly assessment ent Reference Date (ARD) of ident was coded with a Brief tal status (BIMS) score of 3 in possible 15 points, indicating impairment. The Resident was no behavior problems, and istance of staff for all activities in the only exception being uired extensive assistance. The co coded as always incontinent of er. observed on 2-17-16 on bed m. The Resident was found to alert, but confused. Resident #8 red on 2-18-16 at 9:00 a.m. in eyes closed. The Resident e and was easily aroused, and talkative, but confused. a history of bowel impaction and b. The Resident was not rel regimen agents, that were physician was not made aware rel movement in 3-4 days on 2 s ordered, in January & limation report which is y day by Certified Nursing s) provided by the DON was port revealed that on 1-19-16, l-16 (3 days), the Resident had	ABILITATION NUMBER: 495189 ABILITATION CENTER ABILITATION CENTER PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION NA 23692 PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPREDIATION OF CORSECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPREDIATION OF CROSS-REFERENCED TO THE APPREDIATIO

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 02/18/2016
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	no bowel movemen intervention of the E according to the MA record). The Doctor omission of the sup that the Resident has for the above dates physician The Nursing progresevealed no notifical problem had occurre problem was specified ue to repeated host particular problem. Physician orders we bowel program, and 1. Check for bowel hours, if no BM comboctors) for further to unspecified constitutions appositely rectally fecal impaction, Givin 48 hours. Ordered 3. Miralax Powder gatime per day related ounces of water. O	de (4 days), the Resident had to the total	F 19	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 157	Continued From pag		F 157	7	
	suppository was not or February 2016, do occasions the Resid for 3 days on 1 occasion. No where in the clinical occasion.	revealed that the Dulcolax given at any time in January espite the fact that on 2 ent had no bowel movement sion, and for 4 days on 1 cal record was there			
	notified, or aware, the a bowel movement in no notification of the suppositories had no	ed that the physician was let the Resident had not had in 3-4 days. There was also doctor that Dulcolax of been administered, on both een ordered by the doctor.			
	reviewed, and comp care plan. The Resi developed to provide services, and direct	recent care plan was ared to the 7-2-15 canceled dent care plan must be ed necessary care and care to meet the identified The findings are as follows:			
	follows; The Reside constipation related created date was 7-2 canceled care plant interventions on it, at the changed interventions were; needed. and Record each day. Describe consistency. The old the 7-2-15 care plant effects of constipation	to decreased mobility. The 2-15, however, the old 7-2-15 did not have these nd no revision date exists for nations on the new care plan. Assess bowel sounds as I bowel movement pattern amount, color, and d care plan interventions on were; Monitor meds for side on. Keep physician informed conitor/document/report PRN and symptoms of			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	11 11		STREET ADDRESS, CITY, STATE, ZIP O 112 N CONSTITUTION DR GRAFTON, VA 23692		02/18/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	treat the constipation care plan, nor was the no bowel movement of the DON was interview interventions were not doctor had not been administered was not notified of the Her response was "I of Review of the facility." Administration reveal administered as present the written orders of a An interview was con Nursing, (DON), and of day debrief on 2-13-16 at 4:00 p.m	d, and routine medications to were not included, in either e order to call the doctor if occurred in 48 hours. ewed and asked why the ot in the care plan, why the notified of the lack of bowel the Dulcolax suppository had d as ordered,. The doctor e dulcolx not being given. don't know." s policy for Medication ed: medications are cribed in accordance with	F	157		

C 02/18/2016
E COMPLETION TE DATE

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	DATE	
F 157	the investigation, that not been informed. The responsible party continued responsible party elopement by the grant Resident. The administrator and failure of the staff to it of Resident #17's elo 2/18/16 at 11:30 a.m. INVESTIGATE/REPOALLEGATIONS/INDIVESTIGATE/REPOALLEGATION	been unaware, at the time of the responsible party had the DON further stated the stacted her (the DON) after had been informed of the inddaughter of the other. d DON were informed of the inform the responsible party pement from the facility, ORT VIDUALS		225		4/1/16	
	registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for other facility staff to the or licensing authorities. The facility must ensinvolving mistreatment including injuries of unisappropriation of reimmediately to the act to other officials in act through established patterns.	buse, neglect, mistreatment propriation of their property; edge it has of actions by a an employee, which would service as a nurse aide or ne State nurse aide registry is. Liter that all alleged violations int, neglect, or abuse, inknown source and esident property are reported liministrator of the facility and cordance with State law procedures (including to the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		495189	B. WING		C 02/48/2046	
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/18/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 225	prevent further poter investigation is in protein investigation is in protein to the results of all invito the administrator representative and twith State law (includentification agency) incident, and if the a	ghly investigated, and must ntial abuse while the ogress. estigations must be reported	F 22	5		
	by: Based on staff inter and clinical record re for two residents (Re survey sample of 19 unusual occurrence 1. For Resident #16, property, related to r identified on 3/14/15 reported to the OLC certification) until 3/1 2. For Resident #17 SA (state agency) of on 8/7/15 until 8/10/ incident. The findings include 1. Resident #16 was facility on 11/6/14 ar	a misappropriation of missing narcotics, was . The initial incident was not (office of licensure and 9/15. If, the facility did not notify the an elopement that occurred 15, three days after the discontinuity admitted to the did readmitted after 2/15. Diagnoses included		1- Resident #17 was discharged from facility on 9/28/15. Resident #16 was discharged from the facility on 4/29/15 2- The DON or designee will review current resident Incidents to ensure the any unusual occurrences are investigated appropriately and reported appropriate to the agencies in the required time from 3- The Regional Nurse Consultant will educate the Administrator and Nursing Administrative staff on identification of unusual occurrences, alleged violation involving mistreatment, neglect, or abincluding injuries of unknown source as misappropriation of property. They will also be educated on reporting requirements to the State Agency. 4-The DON or designee will review resident incidents on a random weekly basis to ensure that any unusual occurrences are investigated appropriately and reported to the appropriate agencies in the required to	at ated ely ame. S: as use, and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495189	B. WING			1	C 18/2016	
NAME OF PI	ROVIDER OR SUPPLIER	100100		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2016	
REGENCY	HEALTH AND REHABI	LITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 225	set) with an ARD (as 3/23/15 was coded a The resident was code interview of mental signs possible 15, or no concession with the facility of the incident was date 3/14/15, charge nurs practical Nurse) B, a substantial procession of the medication blists sheet for the medication could was received at the fivere administered for resident according to administration record of the medication could was received at the fivere administered for resident according to administration record of the clinical documentation on an Tramadol.	recent MDS (minimum data sessment reference date) of s a quarterly assessment. ded as having a BIMS (brief tatus) score of "15" out of a gnitive impairment. so coded as requiring limited aff member to perform g (ADL's). y's initial Facility Reported 3/19/15 read, resident's property related to (Resident #16)." 's follow-up investigation of ed 3/24/15 and read, "On e, (Name) LPN (Licence and (Name) LPN C noticed by Tramadol for resident, esident #16), was missing. For pack and the narcotic tion was also missing. And the unit was conducted and not be found. The Tramadol facility on 2/2/15 and no pills from the medication to the other medication to the other medication to the other medication."	F	2225	frame. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		ATE SURVEY DMPLETED
		495189	B. WING			C 02/18/2016
	ROVIDER OR SUPPLIER 'HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 112 N CONSTITUTION DR GRAFTON, VA 23692		32/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	the administrator. T investigated the inci the Tramadol was re and to make certain facility." Review of the facility revealed the inciden and was not reported. Review of the facility abuse reporting revealed the incident and was not reported. Administrator will im knowledge of the all Department of Healt Certification."	director of nursing (DON) and the DON stated, "I dent first to make sure that eceived from the pharmacy it wasn't somewhere in the vinvestigation documentation at was identified on 3/14/15 d to the OLC until 3/19/15. It is policy and procedure on ealed the following: "The mediately (within 24 hours of egation) notify the Virginia th Office of Licensure and	F 22	25		
	SA (state agency) or on 8/7/15 until 8/10/incident. Resident #17, a femthe facility 7/20/15 a hospitalization 8/31/cerebrovascular acchyperlipidemia, cata hypertension, vascu constipation. Resident #17's most					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 2/18/2016	
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COI 112 N CONSTITUTION DR GRAFTON, VA 23692		12/10/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 225	assessment. She work long term memory dextensive assistance perform her activitie ambulation, Resider limited assistance. Continent of urine are Review of Resident on 8/7/15 she was fracility. The grandd found Resident #17 the facility. The DON (director of 11:30 a.m., she had elopement until Rescontacted her 8/10/7 The responsible par family member of are assisted her back in Review of the facility investigation was not Resident #17's responsible par facility. The SA was statements were obsystem was checked. The Wanderguard sconnected to the do Resident with a Wardlose to the door. Tand an alarm sound nursing station.	s a significant change has coded as having short and eficits and required limited to be of one staff member to so of daily living. For at #17 was coded as requiring She was also coded as being and bowels. #17's clinical record revealed bound wandering outside of the aughter of another Resident and assisted her back inside of nursing) stated 2/18/16 at been unaware of the ident #17's responsible 15 to discuss the elopement. It is to the facility. It investigation, revealed the of the begun until 8/10/15 when consible party contacted the so notified on 8/10/15. Staff tained and the Wanderguard	F 22	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION		TE SURVEY MPLETED
		495189	B. WING			C 2/18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	, ,	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225		nentation revealed the door	F 22	25		
	alarmed when Resident facility. Review of the facility "Abuse/Neglect/Misa					
	Determination Guide "4. Centers are to re					
	their reporting criteria occurrences immedia occurrences include:	a and report any such ately. Examples of unusual				
	to result in legal action b. Medication en being hospitalized or	on; rrors that result in the patient dying;				
	d. Death or seriouse of restraints;	mpted or successful; ous injury associated with the oxic substances requiring				
	medical interventions f. Accidents or i					
	sustaining an injury of patient being burned					
	medication to result i h. Any unusual	event involving a patient or ult in media coverage or law				
	failure of the facility s Resident #17's elope timely investigation, 2					
F 241	DIGNITY AND RESP	PECT OF INDIVIDUALITY	F 24	F1		4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C)2/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		7271072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241 SS=D	manner and in an en	note care for residents in a vironment that maintains or ent's dignity and respect in	F 24	.1			
	by: Based on observation record review, the farth dignity during a dress area on the sacrum of #6) in a survey sample During a pressure use Resident #6's room open. Also, a male of Resident #6's most in receiving incontinent to her sacral ulcer. The findings include: Resident #6 was addreadmitted 12/15 included but not limit femur, urinary tract in anxiety, diabetes, and deficit. Resident #6's most of sacred to have both short are problems and severe daily decision making requiring extensive to activities of daily living required supervision.	cer dressing change, vindow curtains remained amily member stayed in coobserve her while she was the care and dressing change whitted to the facility 11/6/15 6/16 with diagnoses that the dot of racture of the right effection, hypertension, do cognitive communication ecent MDS (minimum data an ARD (assessment 25/16 assessed the resident		1- Resident #6 was discharged facility on 2/28/16. 2- Current residents with dress observed while nursing staff and dressing changes to ensure the provided in an environment that dignity and respect. 3- The Unit Manager or designeducate licensed nursing staff completing dressing changes in environment that maintains digrespect in full recognition of his individuality. 4-The Unit Manager or designer review residents with dressings random weekly basis to ensure dressing change is done in an environment that maintains digrespect in full recognition of his individuality. Results of the review resented to the quarterly Qual Assurance committee for review recommendation.	ings will be e providing at privacy is at maintains ee will on n an nity and s or her ee will s on a e that the nity and s or her view will be lity		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 241	dressing change to sacral pressure ulcestaff members, LPN and CNA (certified in Resident #6 on her incontinence wear. If from the waist down supporting herself because the from the waist down supporting herself because the design of the design of the design of the dressing changes are dressing of the dresion of the dressing of Resides member was in the After LPN A cleaned member moved closs picture of the wound the man stated, "You a picture of your woobservation ended as On 2/17/16 at approximate the responsible part had informed her the coming to the facility	p.m., an observation of a Resident #6's unstagable or was conducted. Facility (licensed practical nurse) A positioned left side and removed her Resident #6 was exposed. Resident #6 was y holding on to the side rail. Window beside Resident #6's inches). The curtains of the open and never closed during eddressing change, Resident #6 lent and LPN A and CNA A long care. From the sing change, during the lond during the cleaning and lent #6's wound, a male family room watching the Resident. If the wound, the male family room watching the Resident. If the wound, the male family room watching the Resident. If the wound, the male family room watching the Resident. If the wound, a male family room watching the Resident. If the wound, the male family room watching the Resident. If the wound, the male family room watching the Resident. If the wound is approximately 2:50 p.m. with a purpoximately 2:50 p.m. with the man in Resident #6's positionence care and dressing if the man was the resident's to Resident #6's daughter, by (RP). LPN A said the RP at her husband would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the said the room was the resident would be to the room was the room was the resident would be to the said the room was the resident would be to the room was the resident was the resident was the room	F 24	1		
	staff's failure to main during wound care t	nd the DON were informed of ntain Resident #6's dignity o her sacrum with regards to rtains not being closed and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/16/2016	
(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)	JLD BE COMPLETION	
F 241	Continued From pag	e 18	F 24	1		
5.040	incontinence care tall state of undress on 2	•				
F 243 SS=D	GROUP CFR(s): 483.15(c)(1)	PATE IN RESIDENT/FAMILY)-(5)	F 24	3	4/1/16	
	resident's family has facility with the famili facility; the facility must family group, if one estaff or visitors may a group's invitation; and designated staff persistence.	at groups in the facility; a the right to meet in the es of other residents in the ust provide a resident or exists, with private space; attend meetings at the d the facility must provide a son responsible for providing anding to written requests				
	by: Based on observation documentation review provide privacy for a Facility staff failed to Group Interview, by a gathering items for a The Findings included On 2-17-16 at 1:30 F conducted. The door sign on the door that being conducted. The that their privacy working to observe the conducted of the conducted	provide privacy during a entering the room and n unrelated activity.		1- Current residents are provided during group meetings. 2- Resident council meetings or off resident group meetings will be obe by the activities director or designe ensure that the meetings are held i private space without interruption, staff or visitors attending by invitating 3- The Staff Development Coordinatesignee will educate facility staff of providing privacy during a group meattending the group meeting by invitating and that there is a designated person responsible for providing assistance and responding to writte requests that result from group meeting by meeting the group meeting to writte requests that result from group meeting to writte requests that result from group meeting to writte requests that result from group meeting to writte the supplies that the subject to the supplies that the subject to the supplies that the subject to the subject to the supplies that the subject to the supplies that the subject to the subject	ner served e to in a with on only. ator or on eeting, itation d staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	\ '	(3) DATE SURVEY COMPLETED	
		495189	B. WING		0.	C	
NAME OF P	ROVIDER OR SUPPLIER	450105		STREET ADDRESS, CITY, STATE, ZIP CO		2/18/2016	
				112 N CONSTITUTION DR			
REGENC	HEALTH AND REHAB	ILITATION CENTER		GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 243	the process of sharir concerns they had a as other residents. Suddenly, a few resi surveyor noticed sta group through the gl member entered to gmachine. During the 3 different staff mem different times, unan complete their variou and each time said t Staff were asked if the private, and all state meeting was private on the door, but they were strongly as they had prior to the later that incident, the saw the surveyor given member not to enter became quieter and as they had prior to the later was th	ended the group. They were in any information about bout staff members, as well dents, as well as the ff members looking at the ass door. Another staff get a soda from the drink of first half hour of the meeting abers entered the room at anounced and proceeded to us tasks. Each staff member that they "wouldn't be long". They knew the meeting was do that they knew that the and that they saw the sign of would only be a minute. The Residents stated that they we a hand signal for the staff of the room. They generally would not speak as openly the staff disrupting the Group state that they felt that they	F 24	4- The Activity Director or de monitor provision of a private attendance by invitation only follow-up of written concerns resident group meetings. Remonitoring will be presented quarterly Quality Assurance review and recommendation	e space, y, and s from esults of the to the committee for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 243	sign on the door, to h They were made awa time. No further info	nere was something ehind the door, even with the conor that, and not enter." are of the findings at that rmation was provided.	F 24			
F 274 SS=D	facility determines, o that there has been a resident's physical or purpose of this section means a major declir resident's status that itself without further i implementing standa interventions, that had one area of the resid requires interdisciplir care plan, or both.)	ct a comprehensive dent within 14 days after the reshould have determined, a significant change in the mental condition. (For on, a significant change he or improvement in the will not normally resolve intervention by staff or by and disease-related clinical is an impact on more than ent's health status, and harry review or revision of the	F 27	4	4/1/16	
	by: Based on staff intervand facility document failed to complete a status assessment) with determination of a characteristic (Resident survey sample. For Resident #8, the the Resident for a significant significant for a significant survey.	•		 A significant change in status has been initiated with an ARD of 3/8 for resident #8. The MDSC or designee will review current residents with a completed M assessment in the last quarter with a noted decline or improvement in functional abilities to determine a nee a significant change assessment. The Regional Data Analyst and Verification Specialist will educate the 	DS ed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		52/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 274	The findings included Resident #8, was init on 6-5-15. Diagnose dementia, anxiety, gadisease (GERD), pail leading to hospitaliza impaction, and fecal impaction, and fecal impaction, and fecal impaction. Resident #8's most re (MDS) assessment with an Assessment with an Assessment Interview for mental spoints scored in a posevere cognitive impactoded as having no be required total assistated of daily living, with the eating, which required	essing, hygiene and toileting es of Daily Living (ADL's). I: ially admitted to the facility s included; Alzheimer's estro-esophageal reflux n, and severe constipation, tions for small bowel	F 27		review or ties on a re that a t is results of the ommittee		
	comparison, was an an Assessment Refer 6-12-15. The assess assessment was a 5 and was also reviewed 7-8-15. The changes #8 between these two The Admit Assessme Resident #8 as require	MDS assessment used for Admission Assessment with rence Date (ARD) of sment after the admission day quarterly assessment, ed with an ARD date of sexperienced by Resident to assessments follow below: ant dated 6-12-15 coded ring extensive assistance of dressing, hygiene, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495189	B. WING		1	C / 18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02	110/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 274	Continued From pag	ge 22	F 2	74		
	coded Resident #8	assessment dated 7-8-15 as being totally dependent on dressing, hygiene, and				
	(on 10-8-15, and 12 assessments menti reveals that the decitime of survey and c Significant Change a 14 days of recognition the change does no Staff had the opport	S assessments completed -8-15), after the 2 initial oned and compared above, line in ADL's continued to the lid not improve or change. A assessment is required within on of the change and when t improve, or is self limiting. unity for a significant change ompleted in October of 2015, e one.				
	interviewed, and sta declines were in the thought that only co- not necessarily mee significant change.	MDS coordinator was ted because all of the ADL area of coding she unted as 1 change, and did t the requirement of a She was made aware of the t change assessment, and erstood.				
F 279 SS=D	debrief, the Adminis nursing) were notified documentation was	o.m., at the end of the day trator and DON (director of ed of the findings. No further available to be presented. EHENSIVE CARE PLANS	F 2'	79		4/1/16
	_	ne results of the assessment nd revise the resident's of care.				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG	COMPLET		
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHAB	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	' _	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	plan for each reside objectives and times medical, nursing, ar needs that are ident assessment. The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any sed be required under § due to the resident's	velop a comprehensive care ent that includes measurable tables to meet a resident's and mental and psychosocial tified in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided is exercise of rights under the right to refuse treatment	F 2	279			
	by: Based on staff interview, and clinical failed to develop a cresident (Resident 19 residents. Resident #8' had not months. The carepareas, they are; 1). interventions until 2 medication ordered care planned interversurber the bowel pactive for 3 months,			1- Resident #8□s current care comprehensive and includes a to address non-pharmacologic interventions for a psychotropi medication and a care plan to resident□s bowel program. 2- Current residents with psyc medication use and with the n bowel program were reviewed that a comprehensive care pla addresses the resident□s nee 3- The Staff Development Coc designee will educate licensed development of a comprehens plan to include a care plan to a non-pharmacologic interventic psychotropic medication use a address a bowel program as if 4- The Unit Manager or designee to a page 12 to 12 to 13 to 14 to 15 t	a care plan c ic address the chotropic eed for a I to ensure an eds. ordinator or d staff on sive care address ons for and to ndicated.	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495189	B. WING _		C 02/18	B/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		5/2010	
BEOENO	CHEALTH AND DELIAD	II ITATION OFNITED		112 N CONSTITUTION DR			
REGENCY	HEALTH AND REHAB	ILITATION CENTER		GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 24	F 2	279			
	1). Resident #8, was facility on 6-5-15. D Alzheimer's dement reflux disease (GER constipation, leading bowel impaction, and Resident #8's most (MDS) assessment with an Assessment 12-8-15. The Reside interview for mental points scored in a property of a	is initially admitted to the iagnoses included; ia, anxiety, gastro-esophageal (D), pain, and severe go to hospitalizations for small defecal impaction. Trecent Minimum Data Set was a quarterly assessment Reference Date (ARD) of ent was coded with a Brief status (BIMS) score of 3 possible 15 points, indicating pairment. The Resident was behavior problems, and ance of staff for all activities are only exception being ed extensive assistance. The moded as always incontinent of the Resident was found to ref, but confused. Resident #8 on 2-18-16 at 9:00 a.m. in sclosed. The Resident and was easily aroused, dealth to talk ative, but confused. The Resident was found to ref, but confused. The Resident and was easily aroused, dealth to talk ative, but confused. The Resident was found to ref, but confused. The Resident was found to ref, but confused. The Resident and was easily aroused, dealth to the following 5 orders for large and reation Record (MAR) were led the following 5 orders for		complete a random week ensure that resident care comprehensive and inclu address non-pharmacolo for psychotropic medicati address a bowel program Issues noted will be refer Assurance Committee for recommendation.	plans are de a care plan to gic interventions on use and to a as indicated. red to the Quality		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER Y HEALTH AND REHAB	SILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	<u> </u>	32.16/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From pag	ge 25	F 2	79		
	effects): Monitor for drowsing dizziness, nausea, a behavior. Document "Y" (yes) above observed. Document "N" (No) above was observed "other see nurses of findings every shift ordered 7-2-15. 3. Behaviors: Monititiching, picking at skintting, increase in c spitting, cussing, radelusions, hallucina refusing care. Document "Y" (yes) above observed. Document "N" (No) above was observed "other see nurses of findings every shift ordered 7-2-15. 4. Interventions utilizes Psychotropic Med (in Document "Y" (yes) Document "Y" (yes) Document "N" (No) utilized, then select notes" and progress non-pharmacologic related to anxiety st	if monitored and none of the d, then select chart code otes" and progress note related to anxiety state. Itor for the following: Yelling, kin, restlessness (agitation), complaints, biting, kicking, cial slurs, elopement, stealing, tions, psychosis, aggression, if monitored and none of the d, then select chart code otes" and progress note related to anxiety state.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED		
		495189	B. WING _		,	C 2/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pa	ge 26	F 2	79			
	include non-pharma order was as follow Interventions utilized Med (medication)/H 1:1 (one staff to one redirect, activities. Document "Y" (yes) Document "N" (No) utilized, then select notes" and progress non-pharmacologic related to anxiety stated to anxiety state	d before use of Psychotropic lypnotic Med: e resident), reassurance, if not required. if any of the above was chart code "other see nurses is note interventions and interventions every shift tate.					
	January 2016, and 1-4-16, 1-5-16 1-9-1-25-16, 1-30-16, a The Nursing Progre revealed; 1-1-16 at 9:45 p.m. agitation, talked wit ineffective. 1-4-16 at 6:35 p.m. anxiety/yelling, talke ineffective. 1-5-16 at 8:09 p.m. could not redirect, s 1-9-16 at 4:32 p.m.	an was administered in February 2016, on 1-1-16, 16, 1-13-16, 1-17-16, 1-23-16, nd 2-2-16, (10 occasions). The sess Notes were reviewed and Ativan given for increased the patient, gave snack, Ativan given for increased the with patient, gave snack, Ativan given for agitation, snack given, no effect. Ativan given for increased the with patient, gave snack, Ativan given for agitation, snack given, no effect. Ativan given for increased the with patient, gave snack, Ativan given for agitation, snack given, no effect.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		32.16/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	anxiety not able to not 1-17-16 at 1:55 a.m cursing, yelling, resi 1-23-16 at 5:08 p.m unresolved by redire of daily living). 1-25-16 at 3:00 a.m very agitated. Yelling to redirect. 1-30-16 at 4:47 p.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect on the fire very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only, and a significant very agitated. Yelling to redirect only agitated. Yelling to redirect o	Ativan given for increased edirect. Ativan given for anxiety, stive to care. Ativan given for anxiety ection, snack, ADL's (activities ativan given for Resident ag obscenities loudly. unable ativan given for Resident ag obscenities loudly. Unable ativan given for Resident ag loudly. Ativan given for Resident ag loudly. Unable ativan given for Resident ag loudly. Ecords evidenced that of these em happened in the evening tely 4:30 p.m., and 9:30 p.m., e middle of the night between a.m., and 3:00 a.m. No were identified in 5 of the elling was identified in 5	F 2	279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		495189	B. WING _		,	C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHAE	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	care plan was disco of survey. The DON care plan on 2-18-1 document was crea was again asked whithese two care plan was all of the care pfor the Resident, and to why there was no months. There was no care plan created on 10-care plan revealed to the care plan intervent to the care plan intervent to the care plan intervent to adjust to changes of the care plan intervent to adjust to changes of the care plan intervent to the care plan intervent to the care plan intervent to adjust to changes of the care plan intervent to care plan intervent	the period after the 7-2-15 the period the most recent 6, and the date showed the ted on 10-1-15. The DON there the care plan between s was, and she stated that blans that had been completed d she had no explanation as to active care plan at all for 3 plan from 7-2-15 to the care 1-15 (3 months). The 10-1-15 the following; dent exhibits adverse as related to Alzheimer anoid delusions, refuses care the agitation, verbally abusive to the labuse of staff, and refusal at clinically accepted reasons for psychotropic medications dered as used for staff the ty with agitation is not tof specific behaviors. The period of the above were; The provided of the provided of the complete of the staff the provided of the p	F2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	OATE SURVEY COMPLETED		
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pa	-	F 2	79			
	Cue, reorient, and so Of these intervention medication, redirect	ons only effectiveness of the tion, and talking to the umented as being used.					
	No episodes of para hallucinations were record. A thorough review of revealed in the Psy health progress not documented that the mood and affect moday as witnessed by The documents evilindication that Resisparanoia, delusions diagnosed by the experimental progression of the prog	anoid delusions or documented in the clinical of Resident #8's clinical record chiatric physician mental res on 8-5-15 and 12-2-15 re Resident had a depressed ost of the day and nearly every y him, and reported by staff. dence that there was no dent #8 had hallucinations, as or psychosis, and none were expert in mental health. The rated the Resident was only d, with logical and goal th mild confusion, most rer 2015. No diagnosed need or the Ativan by the medical record.					
	were reviewed and pharmacy recomme psychotropic drug r through the time of period with no grad recommended, care. The DON was inter a.m., and when ask interventions were	tered Pharmacist evaluations revealed that there were no endations for needed trials of eduction from June 2015 survey. This is an 8 month ual dose reduction trials e planned or attempted. viewed on 2-18-16 at 11:00 ked what non-pharmacologic used for Resident #8, she on, snacks, and talking to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING A. BUILDING	COMPLETED
495189 B. WING	C 02/18/2016
NAME OF PROVIDER OR SUPPLIER STREET, 112 N CC	DDRESS, CITY, STATE, ZIP CODE NSTITUTION DR DN, VA 23692
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
Resident were used as interventions. Snacks do not appear on the current care plan. No activities are described in the care plan, nor is there a description of what redirection means. None of the other interventions were documented as used. The care plan revealed a second area of focus as follows; The Resident uses psychotropic medication related to anxiety. The interventions for this were; Administer medications as ordered, monitor for side effects, and effectiveness. Guidance is given by the National Institutes of Health, and Centers for Medicare and Medicaid Services as to the appropriate care and treatment of Residents with dementia in regard to psychotropic drugs. That guidance follows; Care Process for a Resident with Dementia Fundamental principles of care for persons with dementia include an interdisciplinary team approach that focuses holistically on the needs of the resident as well as the needs of the other residents in the nursing home. It is important for the facility to have systems and procedures in place to assure that assessments are timely and accurate; interventions are described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice. It is expected that a facility 's approach to care for a resident with dementia follows a systematic care process in order to gather and analyze information necessary to provide appropriate care and services, and that the resident and/or family or representative is engaged throughout the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 0 2/18/2016	
	ROVIDER OR SUPPLIER / HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		1 02110/2010	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 279	E. Monitoring, Follow Identifying the freque impact of behaviors, surroundings or situated help staff and practiti interventions or approach the behaviors. Individe interventions must be behavioral expression dementia. In many sinot be necessary; state automatically assum appropriate treatment evaluation of the resistechniques or environmay prevent certain may include (but are Arranging staffing to resident (e.g., consistent of the extent of the	assessment; on and Diagnosis; are Plan; oroaches and Treatment; oroaches and T	F 27	79			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		e) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 0 2/18/2016	
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279	or surroundings. Fo night in his/her bedi recognizing the staf response; and Matching activities of his/her individual country the specific behavior the assessment. Resident #8 had no attempted in the Atimedications revealed psychotropic drug rethrough the time of interventions that we carried out, psychial performed and diagonal hallucinations, and moderately impaired directed thinking with 2015. No assessment behaviors exists in the planning for the Resmonths, and not follows.	predictably given the situation r example, being awakened at room by staff and not f could elicit an aggressive for a resident with dementia to agnitive and other abilities and ars in that individual based on gradual dose reductions wan, no pharmacy review for ed a need for trials of eduction from June 2015 survey. Non-pharmacologic ere care planned were not tric evaluations were nosed no delusions or stated the Resident was only d, with logical and goal th mild confusion in December ent as to causative factors of the clinical record, and care sident was not done at all for 3 lowed after it was completed.	F 27	9			
	impaction and bowe was not administere were ordered, and t aware of the lack of	o had a history of bowel el obstruction. The Resident ed bowel regimen agents, that he physician was not made bowel movement in 3-4 days was ordered, in January &					
		nination report which is day by Certified Nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	′
		495189	B. WING		C 02/18/201	6
	ROVIDER OR SUPPLIER THEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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)	LD BE COMPL	ETION
F 279	reviewed. The report 1-20-16, and 1-21-16 movement, and on 2-2-16-16, the Residen The Nursing progress revealed no notification problem had occurred problem was specific due to repeated hosp particular problem. Physician orders were bowel program, and reorders; 1. Check for bowel in hours, if no BM contate Doctors) for further into unspecified constitute ourspecified constitute 2. Dulcolax suppository rectally effecal impaction, Give in 48 hours. Ordered 3. Miralax Powder give in 48 hours. Ordered 4. Senna Plus Tablet 2 tablets by mouth at constipation. Ordered	revealed by the DON was revealed that on 1-19-16, the Resident had no bowel 13-16, 2-14-16, 2-15-16 and thad no bowel movement. Is notes were reviewed and on of the doctor that this d. Notification of this ally ordered for this Resident italizations in regard to this revealed the 4 following for the doctor that this d. Notification of this ally ordered for this Resident italizations in regard to this revealed the 4 following for the following for the doctor of the doctor o	F 27			
	or February 2016, de	spite the fact that on 2 ent had no bowel movement				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From pag	e 34 sion, and for 4 days on 1	F	279			
	occasion. No where in the clini	·					
	notified, or aware, th a bowel movement in no notification of the suppositories had no	at the Resident had not had n 3-4 days. There was also					
	care plan. The Resideveloped to provide services, and direct	ecent care plan was ared to the 7-2-15 canceled dent care plan must be ed necessary care and care to meet the identified and the findings are as					
	follows; The Reside constipation related created date was 7-2 7-2-15 canceled care interventions on it, a the changed interver Interventions were; Aneeded. and Record each day. Describe consistency. The old the 7-2-15 care plan effects of constipation of any problems. Mo (as needed) signs ar complications related	to decreased mobility. The 2-15, however, The old e plan did not have these and no revision date exists for ations on the new care plan. Assess bowel sounds as bowel movement pattern amount, color, and dicare plan interventions on were; Monitor meds for side and the control of the constipation.					
	treat the constipation	ed, and routine medications to n were not included, in either ne order to call the doctor if					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495189	B. WING				C 18/2016
	ROVIDER OR SUPPLIER ' HEALTH AND REHABII	LITATION CENTER	•	STREET ADDRESS, CITY, STAT 112 N CONSTITUTION DR GRAFTON, VA 23692	E, ZIP CODE	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 280 SS=D	interventions were not doctor had not been administered was not notified. Her know." Review of the facility' Administration reveal administered as press the written orders of a An interview was con Nursing, (DON), and of day debrief on 2-1' 2-18-16 at 4:00 p.m the findings. No furth by the facility. RIGHT TO PARTICIF CARE-REVISE CP CFR(s): 483.20(d)(3) The resident has the incompetent or other incapacitated under the participate in planning changes in care and A comprehensive assessinterdisciplinary team physician, a registere for the resident, and of the competent of the resident, and of the resident and th	ewed and asked why the of in the care plan, why the notified of the lack of bowel the Dulcolax suppository had d as ordered, and the doctor response was "I don't spolicy for Medication ed: medications are cribed in accordance with attending physicians. Inducted with the Director of the administrator, at the end remainstrator, at the end remainstrator was provided the remainstration was provided the PATE PLANNING (A 483.10(k)(2)). In the state, to g care and treatment or treatment.		280			4/1/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER / HEALTH AND REHAB	ILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 280	and, to the extent protection the resident, the resident, the resident in the	ge 36 cacticable, the participation of ident's family or the resident's and periodically reviewed am of qualified persons after	F 280			
	documentation reviece clinical record review review and revise the for one Resident (Resample of 19 Resident #2, the discontinue restorate Resident #2's care put The findings included Resident #2, a femathe facility 9/30/15. muscular weakness disease, myasthenia disorder, and major Myasthenia gravis is neuromuscular disease.	e facility staff failed to live nursing services from plan. d: lle, was initially admitted to Her diagnoses included gravis, hypertension, mood depressive disorder. a chronic autoimmune ase characterized by varying is of the skeletal (voluntary)		1- Resident #2□s care plan was reto discontinue the restorative progra 2/18/16. 2- Current residents were reviewed ensure that restorative care plans a present for those receiving active restorative services and the care platen revised for those who have be discontinued from restorative service. 3- The Staff Development Coordinateducate licensed staff on revising a resident scare plan when restorative services are initiated or discontinued. 4- The Unit Manager or designee we randomly review residents receiving restorative services and those who been discontinued from restorative services to ensure that the care plant been revised. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	am on to re an has een ees. tor will ive d. iill have	
	set) with an ARD (as 1/7/16 was coded as assessment. She w	recent MDS (minimum data ssessment reference date) of s a modification of a quarterly as coded as having no was able to make her own				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 112 N CONSTITUTION DR GRAFTON, VA 23692	CODE	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	extensive assistance her activities of daily and transferring. Co ambulated in her roo in her locomotion by During a Resident in Resident #2 stated staff in the past. Sh the exercise program Review of Resident was care planned to Rehab/Restorative: stand by assist with needed up to 15 fee able to tolerate" and Exercises lower extrup to 6x/week." Bot were revised on 1/5/ When asked for doc restorative nursing; pursing) stated 2/17. had been refusing the services. The DON been updated when care. The DON furtly determine when Resident #2 had refusioner to the resident #2 had refusioner revealed toward the Resident #4 had refusio	She was coded as requiring to of one to two staff for all of a living including bed mobility ading revealed she had not om and she was independent wheelchair about the facility. Interview, 2/17/16 at 8:10 a.m., she had exercised with the ewas unable to recall when in had stopped. #2's care plan revealed she receive "Nursing Ambulation Program #2 ambulation, use walker as trup to 6x/week as resident is "Nursing Rehab/Restorative: emity exercises as tolerated in care planned interventions 16. umentation of Resident #2's program, the DON (director of 16 at 5:20 p.m., Resident #2 are restorative nursing stated the care plan had not Resident #2 had refused the ner stated she could not sident #2 was discontinued vices. ent #2's restorative care end of January, 2015 used restorative services. aled no further attempts were	F	280		
	Documentation reve made for restorative	aled no further attempts were				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 56.12510		,	
		495189	B. WING		l	18/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PEGENCY	HEALTH AND REHABIL	ITATION CENTER		112 N CONSTITUTION DR		
REGENCI	HEALTH AND REHABIL	HATION CENTER		GRAFTON, VA 23692		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	In any health care set for providing a written. The plan of care some formsIn hospitals ar settings, the client ofte than one nurse, physi professional. A writte possible the coordinar subspecialty consulta diagnostic tests You direct clinical nursing risk of incomplete, incomplete, incomplete does the plan. A nurse guideline for coordinar continuity of care, and be used in evaluation communicates nursing health care profession plan enhances the collisting specific nursing achieve the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the subset of the goals of continuity of care, and the	by "Fundamentals of cotter-Perry, page 268: ting a nurse is responsible pan of care for all clients. etimes takes several and community-based en receives care from more cian, or allied health n nursing care plan makes tion of nursing care, tions, and scheduling of design a written plan to care and to decrease the correct, or inaccurate care. In and status change, so sing care plan is a written ting nursing care, promoting a listing outcome criteria to and the triple of the plan graph of the p	F 28			
F 281 SS=D	failure of the staff to replan to discontinue re 2/18/16 at 11:20 a.m. SERVICES PROVIDE	I DON were informed of the evise Resident #2's care storative nursing services, ED MEET PROFESSIONAL	F 28	31		4/1/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG			LETED
		495189	B. WING _				C 18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE 112 N CONSTITUTION DR GRAFTON, VA 23692	, ZIP CODE	, 02	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 281	must meet profession This REQUIREMEN by: Based on staff interv review, and clinical refailed to follow profes	d or arranged by the facility nal standards of quality. T is not met as evidenced view, facility documentation ecord review, the facility staff ssional standards of nursing	F 2	1- Prilosec for Reside discontinued o 3/916. are receiving medicati	Resident #2 and ions as ordered.	#7	
	two Residents (Resident #1). For Resident #2, administer Prilosec (disease) on 1/11/16 at 2. For Resident #7, administer Levothyro Carvedilol, and Gaba	the facility staff failed to for gastroesophageal reflux at 6 a.m.; and the facility staff failed to exine, Omeprazole, apentin on 1/11/16 at 6 a.m.		2- The Unit Manager of review the medication records and treatment residents to ensure the their medications and ordered. 3- The Unit Manager of educate current licensed documentation guidelity Administration. 4-The Unit Manager of documentation of medicate administration.	administration t records of currer at they are receiv treatments as or designee will sed staff on correct ines for Medication eatment or designee ill revi	ring ct on	
	administer Prilosec (to disease) on 1/11/16 and Resident #2, a femal the facility 9/30/15. It muscular weakness, disease, myasthenia disorder, and major of Myasthenia gravis is neuromuscular disease degrees of weakness muscles of the body.	e, was initially admitted to Her diagnoses included gastroesophageal reflux gravis, hypertension, mood depressive disorder. a chronic autoimmune use characterized by varying s of the skeletal (voluntary)		weekly basis to ensure are receiving medicati as ordered. The result be presented to the quassurance Committee recommendations	e that the residen ions and treatmer ts of the audits wi uarterly Quality	nts	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016	
	ROVIDER OR SUPPLIER / HEALTH AND REHAB	BILITATION CENTER	112	REET ADDRESS, CITY, STATE, ZIP CODE 2 N CONSTITUTION DR RAFTON, VA 23692	·	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 281	1/7/16 was coded a assessment. She was memory deficits and daily life decisions. extensive assistant her activities of dail and transferring. Combulated in her rot in her locomotion but the result of the result o	issessment reference date) of is a modification of a quarterly was coded as having no di was able to make her own. She was coded as requiring se of one to two staff for all of y living including bed mobility oding revealed she had not som and she was independent by wheelchair about the facility. #2's clinical record revealed se 20 mg (milligram) had been at 6 at 6 a.m. A valid physician's for the medication. The DON (director of nursing) at 30 a.m., she could find no station had been administered. The www.pdrhealth.com for illosec: The dose or stop taking Prilosec to your healthcare provider." The policy entitled "General and Medication Administration" Stration of medication, Facility measures required by Facility le Law, including, but not	F 281			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		COMPLETED	
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER / HEALTH AND REHAB	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 112 N CONSTITUTION DR GRAFTON, VA 23692	E	02/10/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 281	correct rate, at the coresident =, as set for Medication Administration Should take all meas policy and Applicable limited to the following 5.4 Administer frames specified by 6. After medication should take all meas policy and Applicable limited to the following should take all meas policy and Applicable limited to the following administration of me "Fundamentals of Nurphysician is responsive treatment. Nurses for unless they believe tharm clients." Also, same source, prequired for every modientRegardless of compare the prescril medication administration wheneved distributed or when conursing unit or health Once you determine	the correct route, at the correct time, for the correct the precent time, for the correct the in Appendix 17: Facility ration Times Schedule: In administration, Facility staff the ures required by Facility et Law, including, but not not not in the medications within time facility policy; In administration, Facility staff the medications within time facility policy; In administration, Facility staff the ures required by Facility et Law, including, but not not not not not not not not not no	F2	281			
	and administer medi	rate, use the MAR to prepare cations." d DON were informed of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495189	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER	400100		STF	REET ADDRESS, CITY, STATE, ZIP CODE	02/	18/2016
REGENCY	HEALTH AND REHABIL	LITATION CENTER			N CONSTITUTION DR AFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page	e 42	F 2	281			
	failure of the staff to a 1/11/16 at 6 a.m., 2/1	administer Prilosec on 8/16 at 11:30 a.m.					
	administer Aspirin, Le	the facility staff failed to evothyroxine, Omeprazole, pentin on 1/11/16 at 6 a.m.					
	the facility 8/12/15 an hospitalization 12/15/ peripheral vascular dicardiovascular disease hypokalemia, osteoar failure, hypertension, allergic rhinitis, dysphbundle branch block, obstructive pulmonar pancreatitis, Vitamin	15. Her diagnoses included isease, arteriosclerotic se, coronary bypass, rthritis, congestive heart angina, muscle weakness, nagia, hypothyroidism, left hyperlipidemia, chronic					
	12/18/15 was coded as hawas able to make her She was also coded a total assistance of on her activities of daily	ecent MDS with an ARD of as a quarterly assessment . aving no memory deficits and r own daily life decisions. as requiring extensive to be staff member to perform living with the exception of esident #7 was coded as					
		7's clinical record revealed wing medications were at 6 a.m.:					
	Aspirin 81 mg (milligr	am) for heart failure					
	Levothyroxine 75 mc	g (microgram) for					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 281	Continued From pa	ge 43	F 28	31		
	Omeprazole Delaye gastroesophageal r	ed Release 20 mg for reflux disease				
	Carvedilol 6.25 for	hypertension				
	Gabapentin 300 mg vascular disease ar	g for pain related to peripheral nd vascular ulcer				
	unable to determine and not documente She further stated t staff to administer r	18/16 at 11:30 a.m. she was e if the medications were given and for or just not administered. The expectation was for the medications as ordered and to er they are administered.				
	_	at www.pdrhealth.com for rilosec (brand name for				
	"What should I avoi medication?	id while taking this				
	, ,	r dose or stop taking Prilosec to your healthcare provider."				
	Guidance for admir www.emedicinehea	nistration of Aspirin at alth.com:				
		ou from having a clot-related way it protects you from ck.				
	reducing the clump cells that clump tog clots. Aspirin keeps	lood's clotting action by ing of platelets. Platelets are lether and help to form blood platelets from clumping ing to prevent or reduce blood				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER 'HEALTH AND REHABI	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIA		
F 281	already-narrowed and oxygen-rich blood to of the brain, in the carduring a heart attack decreases the size of Taken daily, aspirin's prevent a first or second for administration of www.nlm.nih.gov: "Follow the direction carefully, and ask yo explain any part you levothyroxine exactly more or less of it or the prescribed by your decreased by your decre	as, blood clots form in an ery and block the flow of the heart muscle (or to part ase of stroke). When taken a spirin slows clotting and f the forming blood clot. It anti-clotting action helps and heart attack." Levothyroxine at Is on your prescription label are doctor or pharmacist to do not understand. Take as directed. Do not take ake it more often than actor. Is hypothyroidism, but does are several weeks before you our symptoms. Continue to oven if you feel well. Do not xine without talking to your. Carvedilol at Is a around the same time (s) are directions on your efully, and ask your doctor or any part you do not redilol exactly as directed. less of it or take it more often	F 2	281			
	Carvedilol may help	to control your condition but					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	DATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	you feel well. Do not talking to your doctor carvedilol, you may problems such as seattack, or an irregular for administration of www.nlm.nih.gov: "These medications spaced times throug more than 12 hours Follow the direction carefully, and ask you explain any part you gabapentin exactly a or less of it or take it by your doctor. Gabapentin may hell will not cure it. Conting you feel well. Do not without talking to you experience side effer in behavior or mood gabapentin tablets, may experience with	nue taking carvedilol even if a stop taking carvedilol without r. If you suddenly stop taking experience serious heart evere chest pain, a heart ar heartbeat." If Gabapentin at Should be taken at evenly hout the day and night; no should pass between doses. One on your prescription label our doctor or pharmacist to do not understand. Take as directed. Do not take more more often than prescribed p to control your condition but nue to take gabapentin even ot stop taking gabapentin ur doctor, even if you cts such as unusual changes and if you suddenly stop taking capsules, or oral solution, you adrawal symptoms such as ing asleep or staying asleep,	F 2	281		
F 309 SS=E	failure of the staff to Levothyroxine, Ome Gabapentin to Resid orders, 2/18/16 at 1	prazole, Carvedilol and lent #7 per physician's	F3	009		4/1/16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495189	B. WING _			1	C 18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABII	ITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			02/18/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	provide the necessar or maintain the highe mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical,	F3	309			
	by: Based on observation interview, facility door clinical record review provide services to an practicable level of w (Resident #6, #10, #8 sample of 19 resident. 1. For Resident #6, provide pain medicate change to her sacral. 2. For Resident #10, administer 14 medicate Resident #10 's medications were self medications were self more than once daily hypertension, edema chronic pain, muscle reflux, convulsions, locardiovascular disease	ell being for five residents 8, #7 and #13) in the survey ts. the facility staff failed to on prior to the dressing ulcer; the facility staff failed to tions in a timely manner. ications were due for 0 p.m. and were 00 p.m. Resident #10 's neduled to be administer and were ordered to treat , nerve pain, diabetes, pain, muscle inflammation, ow potassium, and se. the facility staff failed to			1- Resident #6 was discharged from the facility on 2/28/16. Resident #10 is receiving medication timely as ordered Resident #8 is having documented reg BMs. The Pharmacist consultant will review the medications for Resident #8 identify any medication irregularities are to ensure that there is clear justification clinical need for the medications. Resident #13 was discharged from the facility on 10/5/15. 2- The Unit Manager or designee will a current residents to ensure that pain medication is available and administered prior to dressing changes as needed. Medication Administration Pass observations will be completed on current Licensed staff to ensure that medication are available for administration, documented and received timely. Current residents receiving psychotropic medications will be reviewed to ensure Pharmacist consultant recommendation were reviewed for current residents to ensure that the recommendations have	ular s to nd n of dent udit ed ent ns ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/18/2016
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/10/2010
				112 N CONSTITUTION DR	
REGENCY	HEALTH AND REHAB	BILITATION CENTER		GRAFTON, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 309	Continued From page	ge 47	F 309	9	
	evaluations, assess Resident being adm medications. Furthe administered bowel ordered, and the ph of the lack of bowel occasions, as was of February 2016. 4. For Resident #7, administer a Fentan orders; 5. For Resident #13 perform a physician	interventions, psychiatric ament, and care planning for a ministered psychotropic er, the Resident was not regimen agents, that were sysician was not made aware movement in 3-4 days on 2 ordered, in January & the facility staff failed to hyl patch per physician 's a, the facility staff failed to ordered blood glucose		been addressed and that there is a justification of clinical need for the medication, and that the non-pharmacological interventions, psychiatric evaluations, assessment care planning is completed appropri The shift report will be reviewed to exthat resident changes in condition and addressed appropriately and that the and RP are notified of any changes condition. The Medication Administrate Records for current residents require blood sugar checks will be reviewed ensure that the blood glucose check documented appropriately. 3- The Unit Manager or designee with the medication and the properties of the second s	t and ately. ensure re e MD in ation ing I to as are
	11/6/15 and readmit that included but no femur, urinary tract anxiety, diabetes, a deficit. Resident #6's most set) assessment wit reference date) of 1 to have both short a problems and sever daily decision makir for one unstagable properties of the compa plan of care for pafor a pressure ulcer	admitted to the facility tted 12/15/15 with diagnoses it limited to fracture of the right infection, hypertension, and cognitive communication recent MDS (minimum data th an ARD (assessment /25/16 assessed the resident and long term memory re impaired cognitive skills for ang. Resident #6 was coded pressure ulcer. rehensive care plan revealed ain as well as a plan of care to the sacrum. Interventions redicate as ordered and to		educate current licensed staff on assessing residents for pain prior to completing dressing changes and providing pain medication as ordere to dressing changes; appropriate timeframe for administration of medications, following recommende medication administration guidelines documentation of medications and to glucose results; identifying, assessin providing appropriate interventions anotification of resident changes in condition; documentation of non-pharmacological interventions, planning, needed psychiatric evalual and will be educated on ensuring the pharmacist consultant recommenda are addressed in a timely manner. 4-The Unit Manager or designee will complete random weekly audits of to glucose checks to ensure that the reare recorded appropriately, review sereport and ensure that changes in	d prior d s for blood ng and and care tions at tions I

PRINTED: 03/28/2018 FORM APPROVED

OLIVILIV	S FUR MEDICARE &	MEDICAID SERVICES			0	MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
				112 N CONSTITUTION DR		
REGENCY	HEALTH AND REHABIL	ITATION CENTER		GRAFTON, VA 23692		
(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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE
F 309	dressing change to R sacral pressure ulcer staff members, LPN (and CNA (certified nu Resident #6 on her le incontinence wear. Desident #6 was very out for the staff to sto Resident #6 that she not going to fall. Resherself by holding on starting the dressing obowel movement and performed incontinencontinued to express the incontinence care when the old dressing cleaned her wound wand as LPN A applied stick to her wound. At change was Resident was she offered anythended at 2:45 p.m. Review of the physici medication orders as "2/5/20016, Percocet tablet by mouth two ti 1/29/2016, Percocet tablet by mouth two ti 1/29/2016, Percocet tablet by mouth two ti 1/29/2015. Tylenol Tevery 8 hours as nee Review of the MAR (I Record) revealed Remedication was admi 9:00 a.m.	esident #6's unstagable was conducted. Facility licensed practical nurse) rsing assistant) A positioned ft side and removed her buring the repositioning, anxious and started yelling p. LPN A encouraged was alright and that she was ident #6 was supporting to the side rail. Prior to change, Resident #6 had a LPN A and CNA A ce care. Resident #6 discomfort. After receiving Resident #6 said 'OW' awas removed, as LPN A ith a 4x4 soaked in saline, at the Santyl with a cotton tip at no time during the dressing to #6's pain assessed or ning for pain. The procedure an orders revealed pain follows: 5-325 mg (milligram) give 1 mes a day for pain. 5-325 mg, give 1 tablet by se as needed for pain. Tablet, give 500 mg by mouth	F3		essed MD and RP are the Unit complete to ensure the ed timely and and The Unit eview mmendations thly basis by that the dressed and psychotropic macological eeded eessment, and the results of to the e Committee	at

observation and she was asked if Resident #6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAE	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	dressing change. A investigate, the DOI where she received scheduled dose of F The administration of 2/18/2016 at 6:00 p. 2. For Resident #10 administer 14 media Resident #10 s me administration at 6:0 administered after 8 medications schedulthan once daily and hypertension, edem chronic pain, reflux, and cardiovascular. Resident #10 was a 07/30/2010 and rea 09/08/2015. Diagnoincluded but are not obstructive pulmona heart failure, and gl. Resident #10's MD ARD (Assessment I 12/15/2015 coded F (Brief Interview of M of 15, cognitively interview)	discation in anticipation of the after taking some time to N stated, "No, I don't see any pain medication after her Percocet at 9:00 o'clock. Was informed of the findings, .m. O, the facility staff failed to cations in a timely manner. Edications were due for 20 p.m. and were 8:00 p.m. Resident #10 had alled to be administered more were ordered to treat his an, nerve pain, diabetes, convulsions, low potassium, disease. Idmitted to the facility on dmitted after hospitalization of coses for Resident #10 tilmited to diabetes, chronic ary disease, hypertension, aucoma. S (Minimum Data Set) with an Reference Date) of Resident #10 with a BIMS dental Status) score of 15, out tact. In addition, the MDS of as independent in all of his	F3	09			
	On 2/16/2016 and a a Medication Pour a Resident #10 was s	approximately 7:50 p.m. during and Pass observation, een in his room, sitting on the esident #10 was receiving					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/18/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 309	legs and feet were On 2/16/2016 at 8: Nurse) was observe medications to Res Resident #10 about said '8' out of a 1-1 wanted to give the first. At 8:20 p.m. If five 20 mg (milligrat washed her hands, medication cart. At 8:25 p.m., RN A #10's medication process medication cart. At 8:30 p.m., RN A following pills into a 500 mg (supplement 100mg (dry eye system); Carve hypertension); Clo Lasix 20 mg (for extrablet (for hyperlipid 30 mg (hypopotass myalgia-muscle pa inflammation); Clo convulsions); Hydr hypertension); Isos heart failure); and (milliequivalent) /15 hypopotassemia) was bottle of Restasis	anasal cannula and both his swollen. 15 p.m., RN (Registered ed preparing to administer ident #10. RN A asked this pain and Resident #10 opain scale. RN A said she resident his pain medication RN A administered Oxycontin, m) tablets (for pain). RN A and returned to the proceeded to take Resident ill cards from the medication generated emandication record). was observed popping the medication cup: L-Arginine in the medication cup: L-Arginine	F 30	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495189	B. WING _			C)2/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 112 N CONSTITUTION DR GRAFTON, VA 23692		22.10,20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	the pharmacy stat. I' and then I'll call the p Gabapentin." RN A oblood pressure and r RN A administered the prepared, washed he medication cart. At 8:50 p.m., RN A sa sugar for his SSI (slicat 4:30 p.m. and it was milligrams/deciliter. V Resident #10 called a needed) Nitrostat (for said he was having of Nitrostat pill in a cup syringe with 15 Units RN A administered to (sublingual-under the injection of 15 units of the Medication Pour p.m. On 2/17/2016 at 8:30 medications administ Pour and Pass Obse Review of clinical recommedications administ pour and p.m. and administered at 6:00 Humalog was due at administered at 8:57 mg that was not avail	said, "I can't find his ing to have to order it from II give him these medications tharmacy for the checked Resident #10's eported a reading of 196/99. The medications she had are hands and returned to the reading scale insulin) was tested as a reading of 191 While at the medication cart, but to RN A for his PRN (as rechest pain). Resident #10 hest pains. RN A placed the and prepared an insulin of Humalog. At 8:57 p.m., a Resident #10 the Nitrostate tongue) and gave an of Humalog. This completed and Pass observation, 9:00 a.m., a review of the tered during the Medication revation was conducted. For deep the ered to Resident #10 he give to Residen	F3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495189	B. WING _				C / 18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309		STAT Box contents revealed	F	309			
	document on any of administered during a pass, except the pair. A review of the Programurse's note written be LPN D, on 2/17/16 a nurse administering 2 (blood sugar), reside came in here and gar Resident refused 230 scared to take anythic double dose.' Evenir	revealed RN A did not the medications she had the Medication Pour and medication, Oxycontin. The sess Notes revealed a py the oncoming night nurse, at 2:44 a.m., "Upon night 2300 meds and checking BS ent states, 'A nurse just we me that medicine." The one of the company of					
	conducted with RN A document on the me administered during the Pass because the bar medication cart went	p.m., an interview was . RN A said she did not dication she had the Medication Pour and tery on the computer on the dead. RN A said she had y now in order to do her					
	the administrator and regarding the late ad #10's medications we said the expectation administer medicatio hour before or after t						
	On 2/17/2016 at 5:30	p.m., the DON provided a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495189	B. WING				C 18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABII	LITATION CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR RAFTON, VA 23692	1 02/	10/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	A's late entry docume administered and a conote that RN A had julti-2/16/2016, 23 Resident #10) inform dinner. Has received he declined his snack monitoring) was reperied for choice given. Repris 70. 2/16/2016 2430 (12:3 informed Gabapentin around midnight. Has sublingual with good. In summation, Resident administered time 4:30 p.m. SSI dose was a blood sugar reading p.m. RN A's failure to administering a slice Resident #10 having Most of the medication late were scheduled p.m. and these medical administered again, julter. Due to the lack medication administration admi	entation of the medications opy of hand written nurse's list written, which read, 30 (Resident's name, ed me that he did not eat his Humalog and Lantus. Also of So BGM (blood glucose ated, found to be 70. Snack ort to night nurse that BGM) 80 a.m.) Night nurse and 2330 meds given directived Nitrostat effect" 19 ent #10's medications were ely. The physician ordered was delivered at 9:00 p.m. for go that was obtained at 4:30 to assess a blood sugar prior ding scale dose, resulted in a blood sugar reading of 70. In that were administered to be given again at 11:30 cations resulted in being ust two and a half hours of documentation after ation, the oncoming nurse, at to administer medication in administered by RN A. The Medication Administration is sent and the reference for standards.	F	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER	11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR 12 RAFTON, VA 23692	1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 309	correct dose, at the time, for the correct 6. After medication should document in administration/treat Guidance was give "Fundamentals of N Potter-Perry, p. 713 medication, record appropriate record medication before a immediately after a The recording of a of the medication."	s the correct medication, at the correct route, at the correct tresidents. administration, Facility staff ecessary medication ment information." en to nursing by Mosby's Nursing 7th Edition, 3, "After administering a it immediately on the form. Never chart a administering it. Recording dministration prevents errors. medication includes the name dose, route, and exact time of	F 309			
	ensure gradual dos non-pharmacologic evaluations, assess Resident being adr medications. Furth administered bowe ordered, and the pl of the lack of bowe occasions, as was February 2016 Resident #8, was in on 6-5-15. Diagno	the facility staff failed to se reductions, sinterventions, psychiatric sment, and care planning for a ministered psychotropic ser, the Resident was not I regimen agents, that were mysician was not made aware I movement in 3-4 days on 2 ordered, in January & mitially admitted to the facility ses included; Alzheimer's gastro-esophageal reflux				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495189	B. WING		1	C / 18/2016	
	ROVIDER OR SUPPLIER / HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	021	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	LD BE	(X5) COMPLETION DATE	
F 309	leading to hospitalizimpaction, and fecal Resident #8's most (MDS) assessment with an Assessment 12-8-15. The Reside interview for mental points scored in a posevere cognitive improded as having no required total assists of daily living, with the eating, which required Resident was also obowel and bladder. Resident #8 was obsawake at 2:30 p.m. be pleasant and aler was again observed bed resting with eye answered to name a pleasant, smiling and The Resident's curred Medication Administreviewed and reveal psychotropic medication. 1. Lorazepam (Ativation one tablet by mouth anxiety related to An Ordered 7-1-15.	in, and severe constipation, ations for small bowel impaction. recent Minimum Data Set was a quarterly assessment Reference Date (ARD) of ent was coded with a Brief status (BIMS) score of 3 possible 15 points, indicating pairment. The Resident was behavior problems, and ance of staff for all activities are only exception being ed extensive assistance. The oded as always incontinent of the Resident was found to a score of the Resident was found to the total confused. Resident #8 on 2-18-16 at 9:00 a.m. in sclosed. The Resident and was easily aroused, dealth that the data incomplete the following 5 orders for ation Record (MAR) were ed the following 5 orders for ation administration; n) 0.5 mg (milligrams) give every 8 hours as needed for existing the side of the	F 30	9			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		MPLETED
		495189	B. WING			C)2/18/2016
	PROVIDER OR SUPPLIER Y HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	behavior. Document "Y" (yes) above observed. Document "N" (No) above was observed "other see nurses not findings every shift in Ordered 7-2-15. 3. Behaviors: Monititiching, picking at sk hitting, increase in cospitting, cussing, race delusions, hallucinar refusing care. Document "Y" (yes) above observed. Document "N" (No) above was observed "other see nurses not findings every shift in Ordered 7-2-15. 4. Interventions utilized Psychotropic Med (in Document "Y" (yes) Document "N" (No) utilized, then select notes" and progress non-pharmacologic related to anxiety states. No non-pharmacologic related in the order the 2-8-16 order characteristics.	if monitored and none of the different monitored and any of the different code of the di	F 30	9		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHA	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 309	Med (medication)/I-1:1 (one staff to on redirect, activities. Document "Y" (yes Document "N" (No) utilized, then select notes" and progres non-pharmacologic related to anxiety selected t	d before use of Psychotropic dypnotic Med: e resident), reassurance, if not required. if any of the above was chart code "other see nurses interventions and interventions every shift tate. revealed that all the form was done by a check did, however, there was no "N", my box for January or February that behaviors the Resident ran was administered in February 2016, on 1-1-16, 16, 1-13-16, 1-17-16, 1-23-16, and 2-2-16, (10 occasions). Resident was administered in February 2016, on sees Notes were reviewed and Ativan given for increased the patient, gave snack, Ativan given for agitation, snack given, no effect. Ativan given for mresolved by redirection and the Ativan given for increased the patient of the properties of the patient of the patien	F 30	9		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(X3) DATE SURVEY COMPLETED	
	495189	B. WING		C 02/18/2016	
			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION	
-17-16 at 1:55 a.m ursing, yelling, resi -23-16 at 5:08 p.m nresolved by redire f daily living)25-16 at 3:00 a.m ery agitated. Yelling redirect30-16 at 4:47 p.m ery agitated. Yelling redirect2-16 at 12:57 a.m ery agitated. Yelling review of these redirect2-16 at 12:57 a.m ery agitated. Yelling review of these redirect of the occurrences, vening between approximate to the occurrences. The noterventions record courrences was talledirection, and a single direction, and a single direction of the single courrence of the first copy of the first copy of the first copy of the single of the surveyors for the surve	Ativan given for anxiety, stive to care. Ativan given for anxiety action, snack, ADL's (activities). Ativan given for Resident g obscenities loudly. unable Ativan given for Resident g obscenities loudly. Unable Ativan given for Resident g obscenities loudly. Unable Ativan given for Resident g loudly. Cords it is evidenced that of 7 of them happened in the approximately 4:30 p.m., and curred in the middle of the approximately 1:00 a.m., and 3:00 ehaviors were identified in 5 and yelling was identified in 5 and yelling was identified in 5 on-pharmacologic ed as used in 2 of the king, and a snack, 2 of mack, 1 of a snack only, 3 with no interventions used. Anitive, behavioral, and the ehensive care plan was 6, and revealed a created date 1, and it was canceled on 1 of Nursing (DON) supplied discontinued 7-2-15 care plan 1 it had been canceled. She 1 et the old care plan, and she 2 et the old care plan, and she 2 et the old care plan, and she 2 et the old after the 7-2-15	F 30			
	SUMMARY S (EACH DEFICIEN REGULATORY OF 2011 A 1:55 a.m. ursing, yelling, resi- 23-16 at 5:08 p.m. nresolved by redire f daily living)25-16 at 3:00 a.m. ery agitated. Yelling oredirect30-16 at 4:47 p.m. ery agitated. Yelling oredirect2-16 at 12:57 a.m. ery agitated. Yelling oredirect2-16 at 3:00 a	A95189 VIDER OR SUPPLIER EALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 -17-16 at 1:55 a.m. Ativan given for anxiety, ursing, yelling, resistive to care23-16 at 5:08 p.m. Ativan given for anxiety nresolved by redirection, snack, ADL's (activities f daily living)25-16 at 3:00 a.m. Ativan given for Resident ery agitated. Yelling obscenities loudly. unable o redirect30-16 at 4:47 p.m. Ativan given for Resident ery agitated. Yelling obscenities loudly. Unable	A BUILDING 495189 WIDER OR SUPPLIER EALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 -17-16 at 1:55 a.m. Ativan given for anxiety, ursing, yelling, resistive to care23-16 at 5:08 p.m. Ativan given for Resident erry agitated. Yelling obscenities loudly. unable or redirect30-16 at 4:47 p.m. Ativan given for Resident erry agitated. Yelling obscenities loudly. Unable or redirect2-16 at 12:57 a.m. Ativan given for Resident erry agitated. Yelling loudly. In review of these records it is evidenced that of nese 10 episodes, 7 of them happened in the vening between approximately 4:30 p.m., and 3:00 m.m., and 3:00 m.m., and 3:00 m.m., No Resident behaviors were identified in 5 of the occurrences, and yelling was identified in 5 occurrences. The non-pharmacologic interventions recorded as used in 2 of the currences was talking, and a snack, 2 of edirection, and a snack, 1 of a snack only, 3 edirect only, and 2 with no interventions used. The Resident's Cognitive, behavioral, and sychotropic Comprehensive care plan was eviewed on 2-17-16, and revealed a created date fo-5-15 to 6-17-15, and it was canceled on -2-15. The Director of Nursing (DON) supplied ne first copy of the discontinued 7-2-15 care plan nd was asked to bring all care plans in their entirety of the surveyors for the period after the 7-2-15 are plan was discontinued, and up until the time	A BUILDING 495189 WIDER OR SUPPLIER EALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 -17-16 at 1:55 a.m. Ativan given for anxiety, urging, yelling, resistive to care23-16 at 5:08 p.m. Ativan given for anxiety dially inresolved by redirection, snack, ADLs (activities of daily living)25-16 at 1:257 a.m. Ativan given for Resident ery agitated. Yelling obscenities loudly. Unable or redirect30-16 at 4:47 p.m. Ativan given for Resident ery agitated. Yelling obscenities loudly. Unable or redirect216 at 12:57 a.m. Ativan given for Resident ery agitated. Yelling obscenities foundly. Unable or redirect1 The very most of the serious proproximately 4:30 p.m., and 3:00 m. No Resident behaviors were identified in 5 fif the occurrences, and yelling was identified in 5 course. The non-pharmacologic terventions recorded as used in 2 of the courrences. The non-pharmacologic terventions recorded as used in 2 of the courrences was talking, and a snack, 2 of defirection, and a snack, 1 of a snack only, 3 adirect only, and 2 with no interventions used. The Resident's Cognitive, behavioral, and sychotropic Comprehensive care plan was seviewed on 2-17-16, and revealed a created date fe-5-15 to 6-17-15, and it was canceled on 2-15. The Director of Nursing (DON) supplied he first copy of the discontinued 7-2-15 care plan and was asked to bring all care plans in their entirety in the surveyors for the period after the 7-2-15. The period of the redirection and she was asked to bring all care plans in their entirety in the surveyors for the period after the 7-2-15.	

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	1		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 309	document was create was again asked whethese two care plans was all of the care please for the Resident, and to why there was no months. There was no care per plan created on 10-1 care plan revealed the As focus; The Residus behavioral symptoms dementia with; Pararat times, anxiety with staff at times, refuse Refusal of care, vertof lab draws are not for administration of and would be conside convenience. Anxietic described in terms of the care plan interverse Administer medication document for side effects adjust to changes of the care plan interverse adjust to change of the ca	is, and the date showed the ed on 10-1-15. The DON ere the care plan between a was, and she stated that ans that had been completed if she had no explanation as active care plan at all for 3. Ilan from 7-2-15 to the care -15 (3 months). The 10-1-15 me following; ent exhibits adverse is related to Alzheimer moid delusions, refuses care in agitation, verbally abusive to is labs. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation is not if specific behaviors. In all abuse of the above were; and as ordered, monitor and fects, and effectiveness. The estimator is inappropriate to the resident. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation is not if specific behaviors. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation is not if specific behaviors. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation is not if specific behaviors. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation is not if specific behaviors. In all abuse of staff, and refusal clinically accepted reasons psychotropic medications ered as used for staff they with agitation, and refusal they are they ar	F 30	09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING_			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 112 N CONSTITUTION DR GRAFTON, VA 23692		12/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pag	ye 60	F 3	09			
	medication, redirecti Resident were docu	ns only effectiveness of the on, and talking to the mented as being used.					
	No episodes of para hallucinations were or record.	noid delusions or documented in the clinical					
	A thorough review of revealed in the Psychealth progress noted documented that the mood and affect moday as witnessed by The documents evidindication that Residing paranoia, delusions diagnosed by the expsychiatrist also star moderately impaired directed thinking with recently in December	f Resident #8's clinical record chiatric physician mental es on 8-5-15, and 12-2-15 es Resident had a depressed est of the day and nearly every thim, and reported by staff. Hence that there is no eent #8 had hallucinations, or psychosis, and none were pert in mental health. The ted the Resident was only l, with logical and goal in mild confusion, most er 2015. No diagnosed need the Ativan by the medical clinical record					
	The monthly Register were reviewed and repharmacy recomment psychotropic drug resulting through the time of s	ered Pharmacist evaluations revealed that there were no endations for needed trials of eduction from June 2015 survey. This is an 8 month all dose reduction trials					
	a.m., and when asked interventions were u stated that redirection Resident were used not appear on the cu	iewed on 2-18-16 at 11:00 ed what non-pharmacologic sed for Resident #8, she on, snacks, and talking to the as interventions. Snacks do urrent care plan. No activities care plan, nor is there a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	, 02
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 309	the other intervention used. The care plan reveal follows; The Reside medication related to for this were; Adminimonitor for side effects. Guidance is given by Health, and Centers Services as to the ap of Residents with depsychotropic drugs. Care Process for a Fundamental princip dementia include an approach that focuse the residents in the nurs the facility to have syplace to assure that accurate; interventio consistently implemental follows.	edirection means. None of ms were documented as led a second area of focus as introduced interventions. The interventions ster medications as ordered, ets, and effectiveness. If the National Institutes of for Medicare and Medicaid oppropriate care and treatment mentia in regard to That guidance follows; Resident with Dementia les of care for persons with interdisciplinary team es holistically on the needs of as the needs of the other ing home. It is important for yetems and procedures in assessments are timely and	F 30		
	for a resident with de care process in orde information necessa and services, and the or representative is e process. It is expecte	facility 's approach to care ementia follows a systematic r to gather and analyze ry to provide appropriate care at the resident and/or family engaged throughout the ed that the resident 's record intation of the following care			

		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING _			C	
	ROVIDER OR SUPPLIER 'HEALTH AND REHABI			STREET ADDRESS, CITY, STATE, ZIP COI 112 N CONSTITUTION DR GRAFTON, VA 23692		2/18/2016	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pag		F 3	09			
	B. Cause Identification	on and Diagnosis;					
	C. Development of C	are Plan;					
	D. Individualized App	proaches and Treatment;					
	E. Monitoring, Follow	<i>y</i> -up and Oversight;					
	impact of behaviors, surroundings or situated help staff and practitic interventions or appropriate behaviors. Individe interventions must be behavioral expression dementia. In many sinot be necessary; stated automatically assume appropriate treatment evaluation of the resist techniques or environ may prevent certain may include (but are appropriate the resident (e.g., consisted to the extending staffing to resident (e.g., consisted to entire the residistress, as well as a patterns, preferences activities to enhance individualize routine that the may be responding presented to the staffing that the	onmental modifications that behavior related to dementia not limited to): optimize familiarity with the tent caregiver assignment); tent possible, factors that ident 's expressions of pplying knowledge of lifelong s, and interests for daily quality of life and					
	activities to enhance individualize routine. Understanding that the may be responding p	quality of life and care. the resident with dementia predictably given the situation example, being awakened at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION NG		COMPLETED	
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 112 N CONSTITUTION DR GRAFTON, VA 23692	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	response; and Matching activities for his/her individual cog the specific behavior the assessment. Resident #8 had no gattempted in the Ativ medications revealed psychotropic drug rethrough the time of sinterventions that we carried out, psychiatri performed and diagnallucinations, and smoderately impaired	r a resident with dementia to initive and other abilities and in that individual based on gradual dose reductions and, no pharmacy review for a need for trials of duction from June 2015 urvey. Non-pharmacologic re care planned were not	F	309		
	2015. No assessme behaviors exists in the planning for the Resimenths, and not follows: Resident #8 also had and bowel obstruction administered bowel of the lack of the lack of bowel of the lack of the lack of bowel of the lack of the lack of bowel of the lack of the l	nt as to causative factors of the clinical record, and care dent was not done at all for 3 wed after it was completed. If a history of bowel impaction on. The Resident was not egimen agents, that were sician was not made aware novement in 3-4 days on 2 dered, in January &				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02210
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 309	and 2-16-16, the R movement. The Nursing progre revealed no notifica problem had occum problem was specific due to repeated ho particular problem. Physician orders w bowel program, and orders; 1. Check for bowe hours, if no BM cord Doctors) for further to unspecified consuppository rectally fecal impaction, Givin 48 hours. Ordered 3. Miralax Powder time per day related ounces of water. 4. Senna Plus Table 2 tablets by mouth constipation. Ordered	2-13-16, 2-14-16, 2-15-16, esident had no bowel ess notes were reviewed and ation of the doctor that this red. Notification of this fically ordered for this Resident spitalizations in regard to this ere reviewed for Resident #8's d revealed the following 4 I movement (BM) every 48 atact LTC (Long Term Care instructions every shift related stipation. Ordered 7-2-15. et intory 10mg, insert one of every 24 hours as needed for every 15 hours as ne	F 309		
	or February 2016, occasions the Resi	ot given at any time in January despite the fact that on 2 dent had no bowel movement easion, and for 4 days on 1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 309	evidence document notified, or aware, the abowel movement no notification of the suppositories had noccasions, as had be reviewed, and compare plan. The Resident #8's most reviewed, and compare plan. The Resideveloped to provide services, and direct needs of a resident follows; The Area of focus of follows; The Reside constipation related created date was 7-7-2-15 canceled call interventions on it, at the changed interventions were; needed, and Record each day. Describe consistency. The of the 7-2-15 care planeffects of constipation.	contact record was there ed that the physician was ever that the Resident had not had in 3-4 days. There was also de doctor that Dulcolax of been administered, on both of been ordered by the doctor. The recent care plan was pared to the 7-2-15 canceled dident care plan must be ded necessary care and care to meet the identified and the findings are as The new care plan was as ent has potential for to decreased mobility. The decreased mobility. The decreased mobility. The decreased mobility. The decreased mobility are plan did not have these and no revision date exists for entions on the new care plan. Assess bowel sounds as decreased bowel movement pattern decreased movement pattern dec	F 309	,	
	treat the constipatio	ed to constipation. ed, and routine medications to on were not included, in either the order to call the doctor if toccurred in 48 hours.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		405400	D WING		С
		495189	B. WING _		02/18/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
REGENCY	HEALTH AND REHABIL	LITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692	
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 309	Continued From page	e 66	F3	809	
	The DON was intervious interventions were not doctor had not been a movement, and why into been administere was not notified of the don't know."	ewed and asked why the at in the care plan, why the notified of the lack of bowel the Dulcolax suppository had d as ordered, and the doctor at. Her response was "I			
	Administration reveal	cribed in accordance with			
	Nursing, (DON), and of day debrief on 2-172-18-16 at 4:00 p.m	ducted with the Director of the administrator, at the end 7-16 at 5:00 p.m., and on They were made aware of er information was provided			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C
	ROVIDER OR SUPPLIER 7 HEALTH AND REHABII			STREET ADDRESS, CITY, STATE, ZIP C 112 N CONSTITUTION DR GRAFTON, VA 23692	ODE	02/18/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From page	e 67	F3	309		
	1	he facility staff failed to I patch per physician's				
	the facility 8/12/15 an hospitalization 12/15/ peripheral vascular disease hypokalemia, osteoal failure, hypertension, allergic rhinitis, dysph bundle branch block, obstructive pulmonar pancreatitis, Vitamin	15. Her diagnoses included isease, arteriosclerotic se, coronary bypass, thritis, congestive heart angina, muscle weakness, nagia, hypothyroidism, left hyperlipidemia, chronic				
	12/18/15 was coded as hawas able to make her She was also coded total assistance of on her activities of daily eating. For eating, R	ecent MDS with an ARD of as a quarterly assessment . aving no memory deficits and own daily life decisions. as requiring extensive to e staff member to perform living with the exception of esident #7 was coded as Resident #7 was coded as				
		erved and interviewed, She was lying on her right verbally responsive.				
	Review of Resident #	7's clinical record revealed a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016
	ROVIDER OR SUPPLIER Y HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 309	(micrograms per ho transdermally every) The patch was ordered #17's complaint of pand peripheral vasc. Guidance for admin was provided at www. "Fentanyl patches a in people who are emedication around who cannot be treated from the same time to the skin. The patches are skin once every 72 about the same time change it. Follow the prescription label capharmacist to explaunderstand. Apply for directed." A corresponding en (electronic medication on the unursing notes reveal.	Patch 72 hour 25 mcg/hr ur) Apply 1 patch 72 hours for pain." Pered in response to Resident pain due to vascular ulcers cular disease. Distration of Fentanyl patch rw.nlm.nih.gov: Pere used to relieve severe pain expected to need pain the clock for a long time and the dwith other medications. The ses of medications called opiate ses. It works by changing the pervous system respond to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHABII	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From page	e 69	F 3	09			
	next time the Fentany was on 2/1/6 (48 hour administration). The DON (director of 11:30 a.m., she had a control medication she determined that when pharmacy on 1/30/16 patch as it had not be (the regular administrentered the one time a day that was not the nurse failed to characteristic the patch to be applied 2/1/16, the prompt can administering medical administering me	nursing) said 2/18/17 at reviewed the eMAR and neets. She stated she had in the patch came from the state of the nurse administered the een available the day before ration day). When the nurse dose order, for the patch on the regular administration day, anged the previous entry for the every 72 hours. On the to the nurse stations to administer the ad not been changed to					
	may be habit-forming patches, apply the pa	n.nih.gov, "Fentanyl patches i. Do not apply more atches more often, or use the way than prescribed by your					
	failure of the staff to a	d DON were informed of the administer Fentanyl patch s, every 72 hours, 2/18/16 at					
		the facility staff failed to ordered blood glucose					
	on 4/25/13 and readr	ginally admitted to the facility nitted after a hospitalization iagnoses of, but not limited					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	COMPLETED		
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 309	obstruction with lys and dementia. Resident #13 was in therefore a closed in therefore a closed in the most Minimum quarterly assessment Reference Date (Al coded Resident #1 impairment; was derequired extensive mobility, transfers, hygiene. On 2/17/15 at 10:00 record was reviewed physician's order derecord was reviewed physician's order derecord was reviewed physician's order derecord was no result Sugar Summary" of On 2/17/16 at 5:45 Director of Nursing On 2/18/16 at 8:35 conducted with the When asked if there regarding the blood stated "I could not be regarding (the) blood regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood in the stated "I could not be regarding (the) blood the stated "I could not be regarding (the) blood the stated "I could not be regarding (the) blood the stated "I could not be regarding (the) blood the stated "I could not be regarding (the) blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be regarding the blood the stated "I could not be rea	s type II, post small bowel is of adhesions, hypertension no longer in the facility record review was conducted. Data Set (MDS) was a ent with an Assessment RD) of 9/27/15. The MDS with moderate cognitive ependent on staff for bathing; assistance from staff for bed dressing, toileting and Da.m. Resident #13's clinical ed. The review revealed a ented 5/8/14 which read: E CHECK two times a day" In the Administrator and were informed of the findings. Jam. an interview was Director of Nursing (Admin-B) erwas any information found and sugar documentation."	F 30	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 323 SS=E	HAZARDS/SUPERV CFR(s): 483.25(h) The facility must ens environment remains as is possible; and e	ISION/DEVICES	F 323		4/1/16
	by: Based on observation review and staff intent to provide a safe environment of the provide as a safe environment of the	t ball was observed in the d: rvation of the facility, the ed. Other F was working in done so for seven years. 16 at 10:50 a.m., she cleaned		1- The dryer vent area was cleaned of 2/18/16. 2- The lint traps on the dryers are cleat a minimum of every three loads. 3- The head of housekeeping will edu housekeeping staff on cleaning the dryents at a minimum of every three loads. 4- The head of housekeeping will complete random weekly observation the dryer vents to ensure that the ventare free of excess lint. Issues noted to be reported to the Quality Assurance committee for review and recommendation.	aned cate yer ads. s of ts

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURY	
		495189	B. WING _			C 02/18/2	016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 112 N CONSTITUTION DR GRAFTON, VA 23692	CODE	02/10/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) MPLETION DATE
F 323	usually seen and she soccer ball size accurs. Other F said she had someone else had be She said she did not morning, before start cleaned at the end of 2/17/16 at 2:30 p.m., that the dryer lint are end of the day on 2/16/16 and Other E stated the dry loads on 2/16/16 and Other E stated the period of the facility Controls Cleaning Seen and the dryer third load. If Processing Worksheed Other A, the head of at 2:25 p.m., he was amount of lint, not or the amount of the social someone accurate the second seriod social size accurate the second seriod size accurate the second size accurate the second seriod size accurate the second size accurat	screens was more than was a had no understanding of the inhulation of lint from dryer. If been out for a few days and een working in the laundry. In check the lint areas in the ting, as the dryers should be founded the previous day. In housekeeping, stated and documentation was evident and been cleaned at the 16/16. A form was presented wer had been run for three down had been cleaned one time. The sence of all that lint was ause a fire." It's policy entitled "Infection chedules" included: The provious first the previous days are the previous day.	F3	323	<u> </u>		
	2/16/16 to thoroughly dryers. Other A state the vacuum had end area. Other A said the dangerous, as it cou	y clean the lint vents on the ed that was how the end of ed up in #3 dryer lint vent nat amount of lint was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/2010
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 323 F 329 SS=D	an excessive amoun	failure of the staff to ensure t of lint was not left in the 2/18/16 at 11:30 a.m. FREE FROM	F 32		4/1/16
	unnecessary drugs. drug when used in eduplicate therapy); owithout adequate moindications for its use adverse consequences should be reduced ocombinations of the educed on a compreher resident, the facility rewho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventions.	nensive assessment of a must ensure that residents intipsychotic drugs are not alless antipsychotic drug to treat a specific condition ocumented in the clinical so who use antipsychotic all dose reductions, and			
	by: Based on staff intervand facility documen	T is not met as evidenced view, clinical record review tation review, the facility staff at (Resident #13) of 19		1- Resident #13 was discharged facility on 10/5/15. 2- The Unit Manager or designed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495189	B. WING _			C 02/18/2016	
	ROVIDER OR SUPPLIER HEALTH AND REHAE	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 112 N CONSTITUTION DR GRAFTON, VA 23692	ODE	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	ge 74	F 3	29			
	residents in the surve Resident #13 was from medications. For Resident #13, the blood pressure of physician ordered properties of the findings included Resident #13 was of the findings included Resident #13 was of the findings included Resident #13 was not a find the total finding finding from the finding finding finding from the finding f	ree from unnecessary ne facility staff failed to hold medication, Lisinopril, per arameters.		review the medication adm record documentation for contestion residents to ensure that the parameters are followed an appropriately. 3 The Unit Manager or deseducate Licensed Nursing appropriately following and medications with paramete 4-The Unit Manager or deserview medications with parandom weekly basis to ensure medication is held or admir ordered and documented at the results of the audits with to the quarterly Quality Ass Committee for review and recommendations	urrent e medication nd documented signee will staff on documenting rs. ignee will rameters on a sure that the nistered as appropriately. Il be presented		
	physician's order da "Lisinopril Tablet 5 M by mouth one time a UNSPECIFIED ESS HYPERTENSION (sic-if) SBP <110 (st	nted 7/2/15 which read: MG (milligrams) Give 2.5 mg a day related to					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495189	B. WING		C 02/18/2016		
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 329	Continued From pa	nge 75	F 329	ð			
	·	ember and October 2015 stration Record (MAR) ing:					
	on the MAR, Blood Progress Notes that a.m. administration through 23, 9/25 & 10/5 the Lisinopril vadministered althoureadings were belo	dings were not documented Pressure Summary or in the at corresponded with the 9:00 of the Lisinopril September 1 9/26. And, on 10/1, 10/2 and was documented as ugh the systolic blood pressure w the physician ordered 99, 10/2=101 and 10/5=105).					
	Director of Nursing blood pressure res	p.m. the Administrator and were informed of the lack of ults in the clinical record and eing held when the systolic is below 110.					
	Preparation and Me included: 4. Prior to adminis staff should take al						
	conducted with the When asked if ther regarding the blood being held or docur "Could not find any blood pressure doc she expected the n	a.m. an interview was Director of Nursing (Admin-B). e was any other information d pressure medication not mented, Admin-B stated she documentation regarding cumentation." When asked if medication to be held and/or n-B shook her head "yes."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495189	B. WING				C 18/2016
	ROVIDER OR SUPPLIER 'HEALTH AND REHABIL	ITATION CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR RAFTON, VA 23692		10,20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page		F	329			
F 332 SS=D	OR MORE CFR(s): 483.25(m)(1) The facility must ensu	the findings. ON ERROR RATES OF 5%	F	332			4/1/16
	by: Based on observation documentation review recommendations, the ensure medications within a 5% medication (Resident #10). 31 m were observed with 2 Humalog Insulin), resident #10, 13 be administered at 6: after 8:00 p.m. One mot available for adminedication pass. And (Humalog) orders we orders. The findings included Resident #10 was ad 07/30/2010 and reading 09/08/2015. Diagnos included but are not little.	e facility staff failed to vere administered with less a error rate for one Resident dedications opportunities 2 errors (Neurotin and sulting in a 6.4% error rate. medications scheduled to 00 p.m., were administered medication (Neurotin) was nistration during the d Sliding Scale Insulin (SSI) re not followed per physician : mitted to the facility on mitted after hospitalization of			1- Resident #10 is receiving medication as ordered in a timely manner, is receiving medications as ordered and medications are available for administration. The Sliding Scale Insuli orders are being followed as ordered for resident #10. 2- The Unit Manager or designee will review current residents with Sliding Scale Insulin orders to ensure that the orders are followed as ordered. The Unit Manager or designee will review current resident medication orders and Medication carts to ensure that medications are available for administration. The Licensed Nursing swill be observed during medication administration pass to ensure that medications are administered timely an as ordered. 3- The Unit Manager or designee will educate Licensed staff on proper method to refill medications, utilization of the facility STAT medication box for needed	n cale nt staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495189	B. WING		02/18/2016	
	ROVIDER OR SUPPLIER Y HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 332	heart failure, and glass Resident #10's MD. ARD (Assessment F 12/15/2015 coded F (Brief Interview of M of 15, cognitively int coded Resident #10 Activities of Daily Liv. On 2/16/2016 at appea a Medication Pour at Resident #10 was sedge of his bed. Resoxygen by way of a feet and legs were sedge of his bed. Resident #10 about said '8' out of a 1-10 wanted to give the riferst. At 8:20 p.m. R (a pain medication), and initialed administ the narcotic sheet at Medication Administ her hands, returned proceeded to take in #10's medication car #10's eMAR. At approximately 8:3 popping the followin medication cup: L-A capsule 100mg, Vita Clonidine .3mg, 3-Lice (Brief Interview).	S (Minimum Data Set) with an Reference Date) of Resident #10 with a BIMS ental Status) score of 15, out act. In addition, the MDS as independent in all of his ving (ADL) care. Proximately 7:50 p.m., during and Pass observation, een in his room, sitting on the resident #10 was receiving nasal cannula and both of his	F 332	medication administration, following Sliding Scale Insulin orders. 4- The Unit Manager or designee will complete random weekly audits of residents with Sliding Scale Insulin or to ensure that the orders are followed appropriately; complete random weel audits of Medication Administration records and the Medication carts to ensure that medications are available administration. The Unit Manager or designee will complete random month medication observations of Licensed to ensure that medications are administered timely and medications available for administration. The resulthe audits will be presented to the quarterly Quality Assurance Committee for review and recommendati	rders d d d f d f f f f f f f f f f f f f f	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHAB	ILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR BRAFTON, VA 23692	1 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 332	Isosorbide 20 mg. If (milliequivalent) /15 separate cup. A bor removed from the madministration. R syringe with 30 units looking through the can't find his Gabap order it from the phathese medications a for the Gabapentin.' #10"s blood pressur 196/99. RN A adm had prepared, wash the medication cart. At 8:50 p.m., RN A sugar SSI was testereading of 191. Wh Resident #10 called needed) Nitrostat (for said he was having Nitrostat pill in a cup syringe with 15 units RN A administered of the tongue) and administered for a decidations administered at 6 decidations adminis	Potassium Chloride 20 meq ml (milliliter) was placed in a title of Restasis .4 ml vial was pedication cart for NA prepared an insulin sof Lantus. RNA then started medication cart and said, "I entin. I am going to have to armacy stat. I'll give him and then I'll call the pharmacy RNA checked Resident e and reported a reading of inistered the medications she ed her hands and returned to chest pain. RNA placed the or chest pain). Resident #10 chest pain. RNA placed the or and prepared an insulin sof Humalog. At 8:57 p.m., the Nitrostat (sublingual-under ninistered the Medication Pour on, 9:00 p.m. O a.m. a review of the stered during the Medication ervation was conducted. Corded revealed the stered to Resident #10 on on and 9:00 p.m. were due to	F 332		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
		495189	B. WING		02/18/2016
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRINCE OF	JLD BE COMPLET
F 332	the pharmacy repo ordered Gabapenti during the Medication 2/16/16. Accord sheet, the Gabapenti 2/17/2016 12:20 a. Review of the facilit Gabapentin was away the facility. The Strapsules of Gabap ordered to have Gabapented to have administering (blood sugar), resincame in here and gasadent refused 2 scared to take anythouble dose." Ever give resident his 23 take his BS. On 2/17/2016 at 4: conducted with RN the Medication Pour A said she did not gasadented to have gabapented to have give resident his 23 take his BS.	ort indicating the arrival of the n that was not administered on Pour and Pass Observation ding to the pharmacy delivery natin was delivered on m. by STAT Box contents revealed railable for administration in TAT Box contained 4 - 100 mg entin. Resident #10 was	F 33	32	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495189	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/18/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 332	Continued From pa	ge 80	F 33	2	
	the administrator an regarding the late ar #10's medications we the expectation was administer medication hour before or after On 2/17/2016 at 5:3 copy of Resident #1 A's late entry docum medications and a conurse's note RN A h " 02/16/2016, 2 Resident #10 inform dinner. Has receive the decline his snack monitoring) was report choice given. Resident #10 informed Gabapentia around midnight. H sublingual with good In summation, Resident administered at 9:00 reading of 191 that some of the medical late were scheduled following shift and the being given in less to summation was supplied to the summation of the medical late were scheduled following shift and the being given in less to summation was supplied to the summation of the medical late were scheduled following shift and the being given in less to summation was supplied to the summation of the medical late were scheduled following shift and the being given in less to summation was supplied to the summation of the summation was supplied to the summation of the summation was supplied to th	dent #10's medications were lely. A SSI dose was p.m. for a blood sugar was obtained at 4:30 p.m. tions that were administered to be given again on the lesse medications resulted in han three hours apart. RN			
	administering a slidi Resident #10 having 70. Due to the lack	a blood sugar prior to ng scale dose, resulted in g a low blood sugar reading of of documentation after ration, the oncoming nurse,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		32113/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 332	Continued From pag	e 81	F3	332		
		d to administer medication n administered by RN A.				
	The facility cited Mos professional nursing	sby as the reference for standards.				
	included the following "4.1 Facility staff shot administered that is a correct dose, at the cotime, for the correct of 6. After medication a should document neadministration/treatm "Fundamentals of Nu Potter-Perry, p. 713, medication, record it appropriate record for medication before actimmediately after additional medication and the following staff in the followi	buld Verify each medication is the correct medication, at the correct route, at the correct residents. Idministration, Facility staff cessary medication ment information." It o nursing by Mosby's cursing 7th Edition, "After administering a immediately on the form. Never chart a dministering it. Recording ministration prevents errors.				
	•	nedication includes the name ose, route, and exact time of				
	called an anticonvulsing nerves in the body the of seizures and some is used in adults to the herpes virus or shing Gabapentin exactly a Carvedilol is a betathe heart and circula arteries and veins). Of heart failure and hypersessing the beart failure and hypersessing the body the beart failure and hypersessing the beart failure and hypersessing the body the beart failure and hypersessing the beart failure	nti-epileptic medication, also sant. It affects chemicals and nat are involved in the cause e types of pain. Gabapentin reat nerve pain caused by gles (herpes zoster). Take as prescribed by your doctor. blocker. Beta-blockers affect tion (blood flow through Carvedilol is used to treat vertension (high blood used after a heart attack that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495189	B. WING_			C 02/18/2016	
	ROVIDER OR SUPPLIER ' HEALTH AND REHABI	11.11		STREET ADDRESS, CITY, STATE, ZIP COD 112 N CONSTITUTION DR GRAFTON, VA 23692	•	02/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE	
F 332	Clonidine lowers blothe levels of certain of allows your blood veto beat more slowly ato treat hypertension. Lasix (furosemide) is that prevents your both salt, allowing the salturine. Lasix treats flupeople with congestion or a kidney disorder syndrome Gemfibrozil helps rettriglycerides (fatty active of these types of fatt with an increased ristriglycerides (fatty active of these types of fatt with an increased ristriglycerides (damages stomach. Pantoprazole is a prodecreases the amous stomach. Pantoprazole stomach acid), Clonazepam is in a geophagitis (damages stomach acid), Clonazepam is in a geophagit	art not to pump as well. od pressure by decreasing chemicals in your blood. This ssels to relax and your heart and easily. Clonidine is used (high blood pressure). a loop diuretic (water pill) ody from absorbing too much to instead be passed in your aid retention (edema) in we heart failure, liver disease, such as nephrotic duce cholesterol and cids) in the blood. High levels in the blood are associated k of atherosclerosis (clogged boton pump inhibitor that ant of acid produced in the bloe is used to treat erosive to the esophagus from	F3	32			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			7 50.25			(С
		495189	B. WING _			02/	18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABIL	ITATION CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR RAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	foods and is needed to body, especially the be Potassium chloride is low blood levels of potassium chloride is low	al that is found in many for several functions of your		332			4/1/16
SS=D	ERRORS CFR(s): 483.25(m)(2) The facility must ensu any significant medica	re that residents are free of					
	documentation review recommendations, the ensure medications was significant medications were not. For Resident #10, 13 be administered at 6:0 between 8:00 p.m insulin (SSI) order was physician orders. 2. medication) was not a during the medication. The findings included Resident #10 was additional recommendation.	e facility staff failed to vere administered timely. ation errors occurred when administered timely. medications scheduled to 00 p.m., were administered 9:00 p.m. 1. A sliding scale s not administered per Gabapentin (a pain available for administration pour and pass observation.			1- Resident #10 is receiving medication as ordered in a timely manner, is receiving medications as ordered and medications are available for administration. The Sliding Scale Insuli orders are being followed as ordered for resident #10. 2- The Unit Manager or designee will review current residents with Sliding Scale Insulin orders to ensure that the orders are followed as ordered. The Unit Manager or designee will review current resident medication orders and Medication carts to ensure that medications are available for administration. The Licensed Nursing swill be observed during medication administration pass to ensure that medications are administered timely and medications are administered timely are	in cale int	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495189	B. WING _				C 1 8/2016
	ROVIDER OR SUPPLIER 7 HEALTH AND REHABI	LITATION CENTER	•	11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR RAFTON, VA 23692	, , ,	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	09/08/2015. Diagnosi included but are not obstructive pulmonar heart failure, and gla Resident #10's MDS ARD (Assessment R 12/15/2015 coded Ro (Brief Interview of Mo of 15, cognitively intacoded Resident #10 Activities of Daily Liv On 2/16/2016 at 7:50 seen in his room, sitt Resident #10 was or cannula. Both of Rewere swollen. On 2/16/2016 at 8:15 and Pass was condunurse) A as she adm Resident #10. RN A his pain and Resident #10. RN A his pain and Resident #10. RN A sairesident his pain med RN A administer Oxytablets. RN A washe medication cart and Resident #10's remain at 8:30 p.m. RN A well Resident #10's remain and Resident #10's remain at 8:30 p.m. RN A well Resident #10's remain at	ses for Resident #10 limited to diabetes, chronic by disease, hypertension, ucoma. 6 (Minimum Data Set) with an eference Date) of esident #10 with a BIMS ental Status) score of 15, out act. In addition, the MDS as independent in all of his ing (ADL) care. 7 p.m., Resident #10 was ing on the edge of his bed. In oxygen by way of a nasal sident #10's legs and feet 7 p.m., a Medication Pour acted with RN (Registered ministered medication to a asked Resident #10 about at #10 said '8' out of a 1-10 d she wanted to give the dication first. At 8:20 p.m., accontin, five 20 mg (milligram) and her hands, returned to the proceeded to prepare	F3	3333	as ordered. 3- The Unit Manager or designee will educate Licensed staff on proper meth to refill medications, utilization of the facility STAT medication box for needed medication administration, following Sliding Scale Insulin orders. 4- The Unit Manager or designee will complete random weekly audits of residents with Sliding Scale Insulin ord to ensure that the orders are followed appropriately; complete random weekly audits of Medication Administration records and the Medication carts to ensure that medications are available fadministration. The Unit Manager or designee will complete random monthly medication observations of Licensed storensure that medications are administered timely and medications are administered timely and medications are available for administration. The results the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	ers y for y taff re s of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495189	B. WING		C 02/18/2016	
	NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR 6RAFTON, VA 23692	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 333	Isosorbide 20 mg. If (milliequivalent) /15 separate cup. A bor removed from the man insulin syringe w started looking throusaid, "I can't find his have to order it from him these medication pharmacy for the Garesident #10"s bloor reading of 196/99. In medications she had the medication cart. At 08:50, RN A said for his SSI was tester reading of 191. LPN Humalog" While at #10 called out to RN Nitrostat (for chest pwas having chest part Nitrostat (sublingual administered the 15 completed the Mediobservation, 9:00 p. On 2/17/2016 at 8:3 medications administer pour and Pass Observeiw of clinical remedications administer observed medication between 8:00 and 9	Potassium Chloride 20 meq ml (milliliter) was placed in a title of Restasis .4 ml vial was redication cart. RN A prepared ith 30 units of Lantus. RN A right the medication cart and a Gabapentin. I am going to a the pharmacy stat. I'll give rins and then I'll call the redication." RN A checked and pressure and reported a RN A administered the diprepared and returned to returned to the medication cart, Resident and A for his PRN (as needed) read at 4:30 p.m. and it was a redication cart, Resident and France and reported the redication cart, Resident and France and reduction cart, Resident and France and reduction cart, Resident and France and reduction cart, Resident and France and Fran	F 333			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2 0	116
	ROVIDER OR SUPPLIER THEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/10/20	716
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COM	(X5) IPLETION DATE
F 333	administered during pass, except the paid pass, except the paid A review of the Programse's note written LPN D, on 2/17/16 and urse administering (blood sugar), residicame in here and gastered to take anyth double dose." Even give resident his 230 take his BS. A review of the physis Insulin were as follows cale: if 101-150 - 5181-210 - 15 units; 25 units; 301-350 = 301-450 = 40 units; 301-450 = 40 unit	the medications she had the Medication Pour and n medication, Oxycontin. ress Notes revealed a by the oncoming night nurse, at 2:44 a.m., "Upon night 2300 meds and checking BS ent states, 'A nurse just one was and states, 'I'm ing else now. I don't want to ing nurse states that she did 100 (11:00 p.m.), meds and ician orders for Sliding Scale ws: "Inject as per sliding units; 151-180 = 10 units; 211-250 = 20 units; 251-300 = 30 units; 351-400 = 35 units; 451-500=50 units. ore meals and at bedtime Scheduled times were 6:30	F 33	33		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 112 N CONSTITUTION DR GRAFTON, VA 23692	DE	02/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 333	conducted with Reg said she did not down had administered down had administer down had administrator arregarding the late a support of the administer had hour before or after hour before or after hour before down had down had before down had before had	20 p.m., an interview was gistered Nurse (RN) A. RN A cument on the medication she uring the Medication Pour and pattery on the computer on the left dead. RN A said she had ity now in order to do her 20 p.m., during a briefing with and the DON, the concerns dministration of Resident were discussed. The DON in was for the nursing staff to ons timely - no more than anothe scheduled time." 20 p.m., the DON provided a lo's February MAR with RN edication administrations and a critten nurse's note RN A had	F3	333	,	
	of choice given. Re is 70. 2/16/2016 2430 informed Gabapent given around midning sublingual with good Drugs.com provided the significant mediadministered timely	d the following information on cations that were not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						l c		
		495189	B. WING				/18/2016	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
				112 N	CONSTITUTION DR			
REGENCY	HEALTH AND REHA	BILITATION CENTER		GRA	FTON, VA 23692			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	 N	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE	
F 333	Continued From page	age 88	F;	333				
	called an anticonv	ulsant. It affects chemicals and						
	nerves in the body	that are involved in the cause						
	of seizures and so	me types of pain. Gabapentin						
	is used in adults to	treat nerve pain caused by						
		ngles (herpes zoster). Take						
		y as prescribed by your doctor.						
		a-blocker. Beta-blockers affect						
		lation (blood flow through						
		. Carvedilol is used to treat						
		ypertension (high blood						
		o used after a heart attack that						
	1	eart not to pump as well. lood pressure by decreasing						
		n chemicals in your blood. This						
		vessels to relax and your heart						
	1	y and easily. Clonidine is used						
		on (high blood pressure).						
		is a loop diuretic (water pill)						
	, ,	body from absorbing too much						
		alt to instead be passed in your						
	urine. Lasix treats	fluid retention (edema) in						
	people with conge	stive heart failure, liver disease,						
	or a kidney disorde	er such as nephrotic						
	syndrome							
		reduce cholesterol and						
		acids) in the blood. High levels						
		at in the blood are associated						
		risk of atherosclerosis (clogged						
	arteries).							
		proton pump inhibitor that						
		ount of acid produced in the						
		azole is used to treat erosive ge to the esophagus from						
	stomach acid),	ge to the esophagus horn						
	, , ,	a group of drugs called						
		ben-zoe-dye-AZE-eh-peens). It						
		n the brain that may become						
		ause anxiety. Clonazepam is						
		re disorders or panic disorder.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495189	B. WING		C 02/18/2016	
	NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 02/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 333	pill) that helps preve too much salt, which Hydralazine is a vast the muscles in your dilate (widen). Isosorbide mononitr called nitrates. It dilamaking it easier for and easier for the homononitrate is used (chest pain). Potassium is a mine foods and is needed body, especially the Potassium chloride low blood levels of Resident #10's SSI administered at 8:57 p.m. prior to act This resulted in Resignificant drop in hof Resident #10's Foreveal his lowest more was 94. Resident #10's Gabarrived 2/17/2016 1. was administered be Review of the facility the availability of 4 - Gabapentin. This in administration at the and Pass, but was in The administrator a the significant media.	ge 89 e is a thiazide diuretic (water ent your body from absorbing in can cause fluid retention. Sodilator that works by relaxing blood vessels to help them eate is in a group of drugs ates (widens) blood vessels, blood to flow through them eart to pump. Isosorbide to prevent angina attacks eral that is found in many dror several functions of your beating of your heart. is used to prevent or to treat cotassium (hypokalemia)." dose of Humalog was 7 p.m. for a blood sugar 1 that was taken at 4:30 p.m. ess the blood sugar level at diministering 15 U of Humalog. Sident #10 experiencing a is blood sugar to 70. Review ebruary blood sugar levels easured blood glucose level easured blood glucose level appentin was ordered stat and 2:20 a.m. The Gabapentin y RN A after she received it. The graph of the Medication Pour not retrieve from the stat box. In the DON were informed of cation errors incurred during and Pass Observation,	F 333			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C 02/18/2016	
	ROVIDER OR SUPPLIER THEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	, == 10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 333	Continued From page 2/18/16 at 6:00 p.m.	e 90	F 33	3		
F 425 SS=D	drugs and biologicals them under an agree §483.75(h) of this pa unlicensed personne law permits, but only supervision of a licen. A facility must provide (including procedures acquiring, receiving, administering of all d the needs of each restant of the facility must empa licensed pharmacis.	ride routine and emergency to its residents, or obtain ment described in rt. The facility may permit I to administer drugs if State under the general sed nurse. The pharmaceutical services is that assure the accurate dispensing, and rugs and biologicals) to meet sident. Tology or obtain the services of the who provides consultation provision of pharmacy	F 42	5	4/1/16	
	by: Based on staff intervreview, and clinical refailed to ensure mediadministration for thre#7 and #10) in a surv	riew, facility documentation ecord review, the facility staff cations were available for ee Residents (Residents' #2, rey sample of 19 Residents. Lotrimin cream, a medicated able for administration on		1- Resident #2 has medications ava and is receiving medications as orde Resident #7 has medications availab and is receiving medications as orde Resident #10 has medications availa and is receiving medications as orde 2- The Unit Manager or designee will review current resident medication administration records and medication	red. le red. ble red.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495189	B. WING _			l	C / 18/2016
	ROVIDER OR SUPPLIER THEALTH AND REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	(microgram) was not on 12/5/15, 1/20/16, 3. For Resident #10, have physician order Glaucoma) available through 02/11/2016. The findings included 1. For Resident #2, I cream, was not availa 2/10/16. Resident #2, a female the facility 9/30/15. Houscular weakness, disease, myasthenia disorder, and major of Myasthenia gravis is neuromuscular disea degrees of weakness muscles of the body. Resident #2's most reset) with an ARD (ass 1/7/16 was coded as assessment. She was memory deficits and daily life decisions. Sextensive assistance her activities of daily and transferring. Codambulated in her room in her locomotion by the set of the second in her room in her locomotion by the second in the seco	Fentanyl patch 25 mcg available for administration 1/29/16, and 2/13/16; and the facility staff failed to ed Xalatan eye drops (for for use from 02/07/2016 : -otrimin cream, a medicated able for administration on e, was initially admitted to der diagnoses included gastroesophageal reflux gravis, hypertension, mood	F 4	125	carts to ensure that medications are available for administration. 3-The Unit Manager or designee will educate Licensed nursing staff on prop procedure to refill medications, utilization of the facility STAT medication box for needed medications. 4- The Unit Manager or designee will complete random weekly audits of medication administration records and medication carts to assure that residen medications are available as ordered. Unit Manager or designee will complete random monthly medication administration observations to ensure the medications are available for administration. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	t The e hat	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495189	B. WING	B. WING		C 02/18/2016	
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/	18/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	her groin. Her physic Cream 1% (Clotrimaz twice a day" on 12/evident on the eTAR administration record being administered to evening shift. On the entry was placed on that Lotrimin AF crea not available. When interviewed, the stated 2/17/16 at 5:19 experienced some profile The DON said the phomedications or at time know that a new presson was needed. Review of the emergurevealed Lotrimin AF the emergency supplementally the facility 8/12/15 are hospitalization 12/15/peripheral vascular dicardiovascular disease	eiving treatment for a rash in cian ordered "Lotrimin AF zole) to be apply to her groin 1/15. Nurses' initials were (electronic treatment) the medicated cream was vice daily until 2/10/16 on evening shift for 2/10/16, and the eTAR and nursing notes, m was not applied as it was be DON (director of nursing) 5 p.m., the facility had oblems with the pharmacy. It is a simple of the ency supply of medications cream was not available in your distriction for Resident #2, and DON were informed of the ensure Lotrimin AF cream ininistration for Resident #2, and DON were informed of the ensure Lotrimin AF cream ininistration for Resident #2, and DON were informed was inistration on 12/5/15, I 2/13/16.	F 43	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495189	B. WING				C / 18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		112	EET ADDRESS, CITY, STATE, ZIP CODE N CONSTITUTION DR AFTON, VA 23692	1 02	10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 425	failure, hypertension allergic rhinitis, dyspl bundle branch block, obstructive pulmonal pancreatitis, Vitamin vascular dementia, a disease. Resident #7's most r 12/18/15 was coded She was coded as his was able to make he She was also coded total assistance of or her activities of daily eating. For eating, Fineeding supervision. Review of Resident a signed physician's or "12/15/16 Fentanyl Finance in the signed physi	angina, muscle weakness, hagia, hypothyroidism, left hyperlipidemia, chronic ry disease, acute D deficiency, varicose veins, and gastroesophageal reflux ecent MDS with an ARD of as a quarterly assessment. aving no memory deficits and rown daily life decisions. as requiring extensive to be staff member to perform living with the exception of Resident #7 was coded as	F	425			
	every 72 hours for part A corresponding entre (electronic medication guidance for the use fresh Fentanyl patch hours. Review of the patch was not applied 1/29/16, and 2/13/16 notes indicated the part was not available from Documentation was indicated, an alternation	ry was noted in the eMAR on administration record) with do patch to be removed and a to be applied every 72 e eMAR revealed a Fentanyl don 12/5/15, 1/20/16, a. An entry within the nursing eatch was not applied as it m the pharmacy.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495189	B. WING			C 2/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 112 N CONSTITUTION DR GRAFTON, VA 23692		2110/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 425	let the facility know the needed to fill Fentan patch, a "hard script" the physician is needed. Review of the facility medications revealed mcg/hour was not avaupply. Guidance is provided of Fentanyl patches: "Do not stop using fetalking to your doctor decrease your dose stop using fentanyl psymptoms of withdratexperience any of the restlessness, teary esteating, chills, musticcles in the center of anxiety, backache, pstomach cramps, difficts staying asleep, naus diarrhea, fast heartboth.	mes, the pharmacy did not nat a new prescription was yl patch. For the Fentanyl or actual prescription from led to refill the medication.	F 4:			
	Resident #7, 2/18/16 3. For Resident #10 have physician order	, the facility staff failed to red Xalatan eye drops (for for use from 02/07/2016				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495189	B. WING		C
	ROVIDER OR SUPPLIER HEALTH AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	02/18/2016
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 425	Resident #10 was ad 07/30/2010 and read: 09/08/2015. Diagnos included but are not I obstructive pulmonar heart failure, and glau MDS (Minimum Data (Assessment Referer coded Resident #10 of Mental Status) sco cognitively intact. In Resident #10 as inde Activities of Daily Livi A review of Resident conducted during the a physician order data read that Resident #1 drops in both eyes even A review of Resident Administration Reconserview showed Resident eye drops from 02/07	mitted to the facility on mitted after hospitalization of es for Resident #10 mited to diabetes, chronic y disease, hypertension, acoma. Resident #10's Set) with an ARD ace Date) of 12/15/2015 with a BIMS (Brief Interview re of 15, out of 15, addition, the MDS coded pendent in all of his ang (ADL) care. #10's clinical record was survey. The review showed ed 11/13/2015. The order 0 was to get Xalatan eye ery day for glaucoma. #10's Medication d was conducted. The ent #10 did not get Xalatan /2016 through 02/11/2016.	F 425		
	findings during a brie approximately 2:45 p present any further in DRUG REGIMEN RE IRREGULAR, ACT O CFR(s): 483.60(c)	m. The facility did not formation about the findings. VIEW, REPORT	F 428		4/1/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495189	B. WING _				C 18/2016
	ROVIDER OR SUPPLIER 'HEALTH AND REHABII	LITATION CENTER		112	REET ADDRESS, CITY, STATE, ZIP CODE N CONSTITUTION DR RAFTON, VA 23692	<u> </u>	10/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	pharmacist. The pharmacist must the attending physicial	e 96 te a month by a licensed treport any irregularities to an, and the director of eports must be acted upon.	F 4	128			
	by: Based on staff intervand clinical record re Pharmacist staff faile medication irregularit (Resident #8) in a su Residents. For Resident #8, the and act upon a " Mor Review" that discuss dose reduction trial a during the administra medication, Lorazepa needed) without clea The findings included Resident #8, was init on 6-5-15. Diagnose dementia, anxiety, ga disease (GERD), pai leading to hospitaliza impaction, and fecal	facility staff failed to report at the need for a gradual fter almost eight months attion of a psychotropic am (Ativan) PRN (as r clinical justification of need. It: ially admitted to the facility as included; Alzheimer's astro-esophageal reflux n, and severe constipation, attions for small bowel			1- Resident #8 will be reviewed by the pharmacist consultant for a review of medication irregularities and the clinical need for the medication has been clarified. 2- Pharmacist consultant recommendations were reviewed for current residents to ensure that the recommendations have been addressed and that there is a clear justification of clinical need for the medication. 3- Licensed staff will be educated on ensuring that pharmacist consultant recommendations are addressed in a timely manner. 4- Pharmacist consultant recommendations will be monitored on monthly basis by the Unit Manager to ensure that the recommendations were addressed. Issues noted will be referred to the Quality Assurance committee for review and recommendations.	a a e ed	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	TE SURVEY MPLETED
		495189	B. WING _			C 2/18/2016
	ROVIDER OR SUPPLIER Y HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		2/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	12-8-15. The Residinterview for mental points scored in a psevere cognitive im coded as having no required total assist of daily living, with teating, which required total assist of daily living, with teating, which required total assist of daily living, with teating, which required total assist of daily living, with teating, which required to any allowed and bladder. Guidance for the act by the National Institutes of Health "Ativan (Loraze USAGE Lorazepam/Ativan (Lorazepam/Ativan (Lorazepam/Ativan (Lorazepam/Ativan (Lorazepam/Management of any short-term relief of the any associated any Any life usuall with an any life usuall with any life u	t Reference Date (ARD) of ent was coded with a Brief status (BIMS) score of 3 ossible 15 points, indicating pairment. The Resident was behavior problems, and cance of staff for all activities he only exception being ed extensive assistance. The coded as always incontinent of diministration of Ativan is given itutes of Health, and is as ry of Medicine, National (NIH) Guidance; epam) INDICATIONS AND lorazepam) is indicated for the citety disorders or for the the symptoms of anxiety or with depressive symptoms.	F 4	28		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	· /	TE SURVEY MPLETED
		495189	B. WING		,	C 2/49/2046
	ROVIDER OR SUPPLIER THEALTH AND REHAB	100,000		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 0	2/18/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	depressive Pre-existing depress during use with Lora benzodiazepines. At recommended for us depressive disorder Benzodiazepines, in alone and in combin depressants, may le respiratory depressic Clinically Significant Benzodiazepines, in to physical and psycolin general, benzodia for short periods onli Extension of the treaplace without reeval continued therapy. Oppoduct is not recomsymptoms (e.g. rebofollowing cessation of as little as one week discontinuation of proagradual dosage-tal after extended theral No episodes of para hallucinations were record. A thorough review of revealed in the Psycolin health progress noted documented that the mood and affect mood and affect mood as witnessed by The documents evidented.	corazepam) is not see in patients with a primary sion may emerge or worsen zepam or other ivan (lorazepam) is not se in patients with a primary or psychosis. cluding lorazepam, both used ation with other CNS ad to potentially fatal on. (See PRECAUTIONS, Drug Interactions) cluding lorazepam, may lead hological dependence. zepines should be prescribed by (e.g. 2 to 4 weeks). International should not take unation of the need for continuous long-term use of mended. Withdrawal bound insomnia) can appear of recommended doses after of therapy. Abrupt oduct should be avoided and pering schedule followed py."	F 42	28		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION CENTER		STREET ADDRESS, CITY, 112 N CONSTITUTION DI GRAFTON, VA 23692	R	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 428	paranoia, delusions of diagnosed by the exp Psychiatrist also state moderately impaired, directed thinking with recently in December or continued use for texpert existed in the or completed month (director of nursing), aby the Registered Phand the DON could a computer. The staff of determine if any recontinued the pharmacist, and in recommendations. To copy of the Pharmacy frame from the date to the physician, and it or recommendations we 6-15-15 until 2-18-16. Resident #8 was observed of the pleasant and alert was again observed to be dresting with eyes answered to his/her or aroused, pleasant, so confused. The Resident's current Medication Administrations we define the continued of the properties of the pleasant, so confused.	er psychosis, and none were ert in mental health. The ed the Resident was only with logical and goal mild confusion, most 2015. No diagnosed need he Ativan by the medical clinical record. unavailable for interview eation Regimen Review's" thly according to the DON and placed in the computer armacist (RPH). Then staff excess the Reviews via were to review and mmendations are made by foo, to act upon those he DON was asked for a verviews to include the time he Ativan was ordered by vas supplied. No re made by the RPH from erved on 2-17-16 on bed he Resident was found to but confused. Resident #8 on 2-18-16 at 9:00 a.m. in closed. The Resident lame and was easily nilling and talkative, but	F	128		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	ge 100	F 4	28		
	one tablet by mouth	on) 0.5 mg (milligrams) give every 8 hours as needed for exist every state unspecified.				
	Antianxiety medic effects): Monitor for drowsing	cation (possible unwanted side				
	dizziness, nausea, a behavior.	aggressive/impulsive				
	above observed.	if monitored and none of the if monitored and any of the				
	above was observed "other see nurses no	d, then select chart code otes" and progress note related to anxiety state.				
	itching, picking at sk hitting, increase in c spitting, cussing, rac delusions, hallucina	or for the following: Yelling, kin, restlessness (agitation), complaints, biting, kicking, cial slurs, elopement, stealing, tions, psychosis, aggression,				
	above observed.	if monitored and none of the				
	above was observed "other see nurses no	d, then select chart code otes" and progress note related to anxiety state.				
	Document "Y" (yes) Document "N" (No)	medication)/Hypnotic Med:				
	notes" and progress	note interventions and interventions every shift				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		SURVEY PLETED
		495189	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	400100		STREE	T ADDRESS, CITY, STATE, ZIP CODE	02	/18/2016
REGENCY	HEALTH AND REHABII	LITATION CENTER			CONSTITUTION DR TON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 428	Continued From page related to anxiety star		F4	128			
	No non-pharmacolog identified in the order the 2-8-16 order char	, and did not appear before					
	include non-pharmac order was as follows; Interventions utilized Med (medication)/Hy 1:1 (one staff to one redirect, activities. Document "Y" (yes) in Document "N" (No) if utilized, then select conotes" and progress	before use of Psychotropic pnotic Med: resident), reassurance, f not required. any of the above was hart code "other see nurses note interventions and atterventions every shift					
	mark, as completed, or "Y", marked in any	evealed that all form was done by a check however, there was no "N", box for January or February t behaviors the Resident					
	January 2016, and Fo 1-4-16, 1-5-16 1-9-16	n was administered in ebruary 2016, on 1-1-16, 5, 1-13-16, 1-17-16, 1-23-16, d 2-2-16, (10 occasions).					
	revealed; 1-1-16 at 9:45 p.m. A agitation, talked with ineffective. 1-4-16 at 6:35 p.m. A	s Notes were reviewed and tivan given for increased patient, gave snack, tivan given for increased I with patient, gave snack,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	B. WING		C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHAE	BILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 12 N CONSTITUTION DR GRAFTON, VA 23692	, 02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 428	could not redirect, s 1-9-16 at 4:32 p.m. agitation/anxiety, ur snack. 1-13-16 at 4:24 p.m anxiety not able to a 1-17-16 at 1:55 a.m cursing, yelling, res 1-23-16 at 5:08 p.m unresolved by redired of daily living). 1-25-16 at 3:00 a.m very agitated. Yelling to redirect. 1-30-16 at 4:47 p.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 2-2-16 at 12:57 a.m very agitated. Yelling to redirect. 3-2-16 at 3:00 a.m very agitated. Yelling to redirect. 3-16 at 4:47 p.m very agitated. Yelling to redirect. 3-2-16 at 3:00 a.m very agitated. Yelling to redirect. 3-17 a.m very agitated. Yelling to redirect. 3-17 a.m very agitated. Yelling to redirect. 3-18 a.m very agitated. Yelling to redirect. 3-19 a.m very agitated. Yelling to redirect. 3-19 a.m very agitated. Yelling to redirect. 3-2-16 at 3:00 a.m very agitated. Yelling to redirect. 3-2-16 at 3:00 a.m very agitated. Yelling to redirect. 3-2-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect. 3-3-16 at 3:00 a.m very agitated. Yelling to redirect.	Ativan given for agitation, mack given, no effect. Ativan given for increased redirect. Ativan given for increased redirect. Ativan given for anxiety, istive to care. Ativan given for anxiety ection, snack, ADL's (activities and obscenities loudly, unable and ativan given for Resident and obscenities loudly. Unable and Ativan given for Resident and obscenities loudly. Unable and Ativan given for Resident and loudly. Ativan given for obscenities and obscenities loudly. Ativan given for obscenities and obscenities loudly. Ativan given for obscenities and obscenities loudly. Ativan given for anxiety and loudly. Ativan given for anxiety and loudly. Ativan given for anxiety and loudly. Ativan given for Resident and loudly. Ativan given for anxiety anxiety and loudly. Ativan given for anxiety anxiety anxiety and loudly. Ativan given for anxiety	F 428		

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495189	B. WING			C 2/18/2016
	VIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692	1 0	2/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
For the second s	dementia with; Parant times, anxiety with staff at times, refuses Refusal of care, verball flab draws are not correct administration of pland should not be additional to the care plan interversional delusions. The care plan interversional delusions adjust to changes. If reasonable, discussional delusions revealed reassurance on one) dedirection, activity. Ask yes/no questions calculation, redirections redirections revealed redirections revealed redirections revealed redirections did not have sufficient with the did not have sufficie	related to Alzheimer oid delusions, refuses care agitation, verbally abusive to labs. al abuse of staff, and refusal linically accepted reasons sychotropic medications ministrated for staff with agitation is not specific behaviors, and in the clinical record of inthe clinical record of sas ordered, monitor and ects, and effectiveness. It is allowing the resident time is resident behavior, behavior is inappropriate to the resident. Interaction, reassurance, interaction, reassurance, interview as needed.	F	128		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495189	B. WING _			C 02/18/2016
	ROVIDER OR SUPPLIER HEALTH AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692		02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	An interview was con Nursing, (DON), and of day debrief on 2-1 2-18-16 at 4:00 p.m	ducted with the Director of the administrator, at the end 7-16 at 5:00 p.m., and on They were made aware of the information was provided	F 4	128		
F 496 SS=D	NURSE AIDE REGIS	·	F4	196		4/1/16
	aide, a facility must re that the individual has requirements unless employee in a trainin evaluation program a individual can prove to successfully complete competency evaluation evaluation program a has not yet been incli	pproved by the State; or the that he or she has recently ed a training and on program or competency pproved by the State and uded in the registry. up to ensure that such an				
	aide, a facility must s State registry establis (2)(A) or 1919(e)(2)(A)	dividual to serve as a nurse eek information from every shed under sections 1819(e) A) of the Act the facility nformation on the individual.				
	a training and compethere has been a conconsecutive months of individual provided not services for monetary	during none of which the ursing or nursing-related compensation, the lete a new training and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
		495189	B. WING			C 2/18/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/10/2010
REGENCY	HEALTH AND REHABIL	LITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
F 496	by:	on program.	F 4			
	review, the facility sta CNA's (certified nursi certified nursing staff after renewal. Employee #2's certified	iew and employee record iff failed to ensure one ng assistant) of three certification was verified cation expired on 11/30/15 verify valid certification until		 1- Employee #2 □s certification was verified on 12/17/16. 2- Current staff requiring a license certification were reviewed to ensit the license or certification is current active and verified in a timely man 3- The Regional HR consultant or designee will educate the current manager on verifying licenses and certifications prior to the expiration 	e or ure that ntly nner. HR	
	employee record revi revealed Emp. #2's c 11/30/15. Documenta record revealed the c	eyee file was reviewed during ew. Documentation ertification expired on ation within the employee ertification was verified by s) on 12/17/15 (17 days		license or certification. 4- The Regional HR consultant or designee will complete a random audit to ensure that licenses and certifications have been verified p the expiration. Issues noted will b referred to the Quality Assurance committee for review and recommendation.	monthly	
	p.m., she checks eve twice a month to dete license/certification a provided documentat 12/1, 12/3, 12/4, 12/7 12/14, and 12/15/15. Other D said she mad an expired license, he no other verification of the administrator and	HR, stated 2/17/16 at 2:36 ryone license/certification remine which re due to expire. Other D ion that Emp. #2 worked 7, 12/8, 12/10, 12/12, 12/13, de sure no one worked on owever she stated she had of certification after renewal.				

NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 496 Continued From page 106 certification after renewal for Emp. #2 in a timely manner, 2/17/16 at 5:15 p.m. C 02/18/2016 STREETADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 496 Continued From page 106 certification after renewal for Emp. #2 in a timely manner, 2/17/16 at 5:15 p.m.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 496 Continued From page 106 certification after renewal for Emp. #2 in a timely			495189	B. WING			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 496 Continued From page 106 certification after renewal for Emp. #2 in a timely					112 N CONSTITUTION DR		2/16/2016
certification after renewal for Emp. #2 in a timely	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETION
	F 496	certification after ren	ewal for Emp. #2 in a timely	F 4	96		