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	495340	A. BUILDING _____ B. WING _____	C 05/19/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 05/17/16 through 05/19/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. Five (5) complaints were investigated during the survey.

The census in this 102 bed facility was 100 at the time of the survey. The survey sample conisted of 17 current Resident reviews (Residents #1 through 17) and 5 closed recored reviews (Residents #18 through 22).

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on medication pour and pass observation, staff interview, facility document review and clinical record review the facility staff failed to ensure they were free of medication error rates 5 percent (%) or greater. There were 26 observed medication opportunities with 3 errors, resulting in an 11.53% medication error rate. The residents involved in the medication errors were Residents #14 (*Thera and *Acarbose 25 milligrams) and #13 (Thera M).

1. Resident #14 was not administered Thera per physician's order, instead Thera Vital M was administered. Also, Acarbose 25 milligrams (mg)

F 000

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This plan of correction will serve as the facility's allegation of substantial compliance.

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F 332

1. Resident #14 & #13 had no adverse effects from the med errors. LPN #34 was in-serviced and counseled on both medication errors for resident #14 on 5/18/16. Physician has been made aware of med errors made on resident #14 on 5/18/16. Resident #14 family was also made aware of medication errors on 5/18/16. LPN #2 was in-serviced and counseled on her medication error for resident #13 on 5/18/16. Physician has been made aware of med error on 5/18/16 Resident #13 family was also made aware of medication error on 5/18/16.
2. Residents who have orders for either Thera or TheraM have the potential to be affected. Residents that have orders for Acarbose have the potential to be affected.
3. The Director of Clinical Services or designee will provide an in-service to all LPN/RN staff on Medication Delivery, the 5 rights of medication administration and following physician's orders. Omnicare pharmacy will come in and observe and report on medication passes on 3 shifts for LPN/RN and report findings to DCS.
4. The Director of Clinical Services or designee will conduct random observation of LPN/RN medication passes 4 times a week on one of the three shifts for one month and then 2 times a week on one of the three shifts for one month. Licensed nurses who continue to have med error rates will receive additional mentoring, education and oversight from DCS/designee. The results of the audits will be reviewed at the monthly Quality Assurance meeting for review, analysis, and further recommendations.

5. A.O.C. - 7.1.16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim Executive Director	6/7/16

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

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was omitted.

2. Resident #13 was not administered Thera Vital M per physician's orders, instead Thera was administered.

The findings included:

1. On 5/18/16 at 9:45 a.m., Licensed Practical Nurse (LPN) #34 administered Thera Vital M during a medication pass observation. The resident had physician's orders dated 5/13/16 for plain Thera (multivitamin) 1 tablet by mouth once a day.

*Thera medication is an oral multivitamin product without minerals used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Thera is a multivitamin without minerals (http://www.webmd.com/drugs/2/drug-9953/thera-multi-vitamin-oral/details).

*Thera Vital M medication is an oral multivitamin product with minerals (http://www.webmd.com/drugs/2/drug-16911/thera-vital-m-oral/details).

On 5/18/16 at approximately 12:00 p.m., an interview was conducted with LPN #34. She checked the medication cart and was not able to locate plain Thera without minerals. She verified she gave Thera Vital M and stated, "I was told the two medications were interchangeable and they were the same."

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On 5/18/16 at 9:45 a.m., LPN #34 omitted the medication Acarbose 25 milligrams (mg) by mouth. It was verified two times there was 8 tablets in the medication cup prior to the nurse crushing them.

*Acarbose is an oral medication used along with a proper diet and exercise program to control high blood sugar in people with type 2 diabetes (http://www.webmd.com/drugs/2/drug-5207/acarbose-oral/details).

The Director of Nursing (DON) was made aware of the medication errors on 5/18/16 at 11:30 a.m.

On 5/18/16 at approximately 12:00 p.m., an interview was conducted with LPN #34 at the medication cart. She stated she was unaware she failed to give the Acarbose, but verified she recalled the number of tablets in the medication cup was 8, but there should have been 9 in the cup.

The aforementioned medication errors were brought to the attention of the Administrator and re-addressed with the Director of Nursing (DON). No further information was provided prior to survey exit.

Resident #14 was re-admitted to the nursing facility on 5/13/16 with diagnoses that included type 2 diabetes mellitus controlled on oral medication, Acarbose. The resident had no physician orders for Finger Stick Blood Sugar (FSBS) accuchecks.

The Minimum Data Set (MDS) dated 5/13/16 indicated the resident was a 15 out of possible score of 15 on the Brief Interview for Mental

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Status (BIMS) which indicated the resident was intact in the skills needed for daily decision making.

The facility's policy titled "Medication-Oral Administration of" dated 11/30/14 indicated "...Compare unit/dose medication on MAR (Medication Administration Record). Read label on the container THREE (3) TIMES: BEFORE REMOVING the drug from the drawer; BEFORE HANDING the drug to the resident; and BEFORE DISCARDING package..."

3. The facility staff failed to ensure that Resident #13 was administered the physician ordered Thera-M (multi-vitamin with minerals) instead of Thera-Tabs Geri-Care High Potency without minerals during a medication observation pass.

Resident #13 was a 97 year old admitted to the facility on 5/31/12 with diagnoses to include *Protein-Calorie Malnutrition, **Adult Failure to Thrive, and ***Alzheimer's Disease.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 4/4/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 10 which indicated that Resident #13 was cognitively intact and capable of daily decision making.

Resident #13's current Comprehensive Care Plan that was completed and reviewed on 4/14/16 documented in part, as follows:

Focus: The resident has potential for imbalanced nutrition r/t (related to) multiple diagnosis, poor

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skin turgor, cognitive loss, poor intake, altered mental status, comfort care.

Interventions:
*Administer medications as ordered. Monitor and report for side effects and effectiveness.

The Medication Administration Record dated 5/1/16-5/31/16 indicated the following order with a start date of 10/11/15: Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth every day shift for supplement. From 5/1/16-5/18/16 the above medication was initialed by nursing as being administered as ordered.

On 5/18/16 at 8:40 a.m. a Medication Administration Observation for Resident #13 with LPN (Licensed Practical Nurse) #2 was completed.

During the Medication Administration Observation LPN #2 poured and administered 1 tablet from a bottle labeled Thera-Tabs Geri-Care High Potency for Resident #13. A review of the Thera-Tabs Geri-Care High Potency bottle indicated that the medication did not contain minerals.

On 5/18/16 at 10:15 a.m. a phone interview was conducted with the facility Pharmacist. During the phone interview the Pharmacist was asked if Thera-Tabs Geri-Care High Potency contained minerals and was it the same as Thera-M. The Pharmacist stated, "No, they are not the same as Thera-M. Thera-M contains minerals, the other does not."

On 5/18/16 at 9:50 a.m. the Over the Counter Cabinet in the Medication Room on Rosewood

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was checked for the medication Thera-M with the Director of Nursing. After inspection of the cabinet the Director of Nursing stated, "There is no Thera-M in here." Approximately 45 minutes later the Director of Nursing stated that a bottle of Thera-M was available in the other medication cart on the unit; however, LPN #2's medication cart was inspected by the surveyor and there were no bottles of Thera-M available.

On 5/18/16 at 2:08 p.m. an interview was conducted with LPN #2 about the medication error early that morning with Resident #13 and was asked why Thera-Tabs Geri-Care High Potency was administered instead of the physician ordered Thera-M. LPN #2 stated, "Because I heard one nurse say that it was the same as the Thera-M because it was high potency. I called the family and the doctor to clarify that I gave the regular multivitamin instead of the multivitamin with minerals. I should have given the Thera-M, I usually work 11-7; I will never make that mistake again."

Resident #13's Nurse's Note dated 5/18/16 at 3:59 p.m. documented in part, as follows:

MD/RP (medical doctor and responsible party) AWARE RESIDENT RECEIVED THERA TAB (tablet) MULTIVITAMIN INSTEAD OF THERA VITAL-M THIS SHIFT.

The facility policy titled, "Medications-Oral Administration Of, effective date 11/30/14 documented in part, as follows:

Policy: It is the policy that the resident can expect safe and accurate administration of oral medication.

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Procedure:
Locate prescribed medication in Medication Cart. Stock Medications are on the bottom shelf. Compare unit/dose medication on MAR (medication administration record). Read label on container THREE (3) TIMES: BEFORE REMOVING the drug from the drawer; BEFORE HANDING the drug to the resident; and BEFORE DISCARDING package.

A pre-exit interview was conducted on 5/19/16 at 3:30 p.m. with the Administrator, Director of Nursing, Regional Director of Clinical Services and the Case Mix Coordinator in attendance. The above findings were presented.

Prior to exit no further information was provided by the facility.

*Protein-Calorie Malnutrition: a wasting condition resulting from a diet inadequate in either protein or energy (calories) or both.

**Adult Failure to Thrive: weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol.

***Alzheimer's Disease: a condition characterized by progressive mental deterioration, often with confusion, memory failure, disorientation, restlessness, speech disturbances, inability to carry out purposeful movement, and hallucinosis.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health

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F 332	Continued From page 7 Professions 8th Edition.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, facility documentation, and staff interviews the facility staff failed to meet the needs of a resident by not acquiring and receiving a scheduled medication in a timely manner upon admission to the facility for 1 of 22 Residents in the survey sample, Resident #22. The facility staff failed to acquire and receive Resident #22's physician ordered scheduled	F 425	1. Resident #22 has been discharged from the facility on December 11, 2015. 2. All residents that are admitted to the facility with a Xanax order or receive a new order for Xanax have the potential to be affected. 3. The Director of Clinical Services or designee will in-service all LPN/RN staff on the proper procedure of obtaining medications at the facility for new admissions in a timely manner, utilizing pharmacy stat box and to ensure all medications are given in a timely manner. 4. All new admissions will be audited by Director of Clinical Services or Designee to ensure medications were delivered and dispensed in a timely manner for new admissions and new orders, 5 times a week for one month, and then three times a week for one month. The results of the audits will be reviewed at the monthly Quality Assurance meeting for review, analysis, and further recommendations. 5. A.O.C. – 7.1.16	

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Xanax medication within a timely manner upon admission to the facility.

The findings included:

Resident #22 was a 73 year old admitted to the facility on 12/5/15 with diagnoses to include, *Anxiety Disorder, **Hypertension, and ***Congestive Heart Failure.

*Xanax: a controlled substance schedule IV, Benzodiazepine. Action: Unclear: Thought to act at limbic, thalamic, and hypothalamic levels of the central nervous system to produce sedative, anxiolytic, skeletal muscle relaxant, and anticonvulsant effects. Indications: Anxiety disorders. Clinical Alert: Don't withdrawal drug suddenly. Seizures and other withdrawal symptoms may occur unless dosage is tapered carefully.

The above definitions was derived from McGraw-Hill NURSE"S DRUG Handbook 7th Edition.

The most recent Comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 12/11/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #22 was cognitively intact and capable of daily decision making. Under Section I Active Diagnoses 15700 Anxiety Disorder was coded.

The Hospitalist Discharge Summary 12/5/15 at 9:45 a.m. for Resident #22 documented in part, as follows:

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DISCHARGE DIAGNOSES:
7. History of generalized anxiety.

HOSPITAL COURSE:
6. Anxiety. Patient has a known history of anxiety. On admission, she was on scheduled Xanax and receiving as-needed medicine to help manage that.

TAKE THESE MEDICATIONS
ALPRAZOLAM (XANAX) 0.5 mg (milligram)
Tablet-1 tablet oral three times a day.

Resident #22's facility History and Physical completed on 12/7/15 documented in part, as follows:

Medication List: xanax 0.5 tid (three times a day)
Past Medical History: hx (history) of anxiety
Physical Exam: Psychiatric: Knew her meds (medications) and past med. (medical) history.

The facility Admission/Readmission Data Collection tool dated 12/5/15 at 12:29 p.m. for Resident #22 documented in part, as follows:

O. Mood and Behavior:

3. Indicators of Depression, Anxiety, Sad Mood: Checked for Resident #22:
3a. Verbal expressions of distress
3b. Sleep cycle issues
3c. Loss of interest
5. Potential Causes/Triggers of Mood/Behaviors: Checked for Resident #22:
5a. Little of no interest in doing things
7a. Noise (Environment)
8a. Pain (Illness/Condition)

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F 425	Continued From page 10 P. Medication Review: 7. Anti-anxiety-yes 7a. Name-Xanax A review of Resident #22's 12/5/15 admission orders was completed. A phone order dated 12/5/15 at 1:16 p.m. documented in part, as follows: Xanax Tablet 0.5 mg (Alprazolam) Give 1 tablet by mouth three times a day related to GENERALIZED ANXIETY DISORDER. The scheduled facility times for administration were: 9 a.m., 1 p.m., and 5 p.m. The above telephone order was signed by the Prescribing Physician on 12/7/15 at 6:13 p.m. The facility Daily Skilled 8 Hour Nurses Noted dated 12/6/15 at 10:26 p.m. documented in part, as follows: Resident voiced being upset for not having Xanax for the day, MD (medical doctor) on call informed per outgoing nurse, and several attempts to reach on call for prescriptions. Resident was kept informed of the situation and received the medication as soon as order became available from the red box (emergency box). This nurses note was signed by the nurse on 12/7/15. On 5/18/16 at 3:30 p.m. a phone interview was conducted with the Complainant regarding allegations of medications not received in the complaint. The Complainant stated, "It took over 2 days for the Xanax to get to the facility, they had to keep calling and calling the doctor."	F 425		

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The facility Control Stat Box 1 contents list was provided to the surveyor by the Director of Nursing. The Control Stat Box 1 contents list documented in part, as follows:

ALPRAZOLAM 0.5 mg tablet QTY: (quantity) 3 EACH

The Facility Pharmacy Proof of Delivery Report with date range of 12/5/15-12/11/15 documented in part, as follows:

Delivery Manifest #: 522086-5
Order #: R9849341
Item Description: ALPPRAZOLAM 0.5 MG Tablet
Date Shipped: 12/6/15
Date Received: 12/7/15 12:09 a.m.

Resident #22's Medication Administration Record (MAR) dated 12/1/15-12/31/15 documented in part, as follows:

Xanax Tablet 0.5 MG (ALPRAZOLAM) Give 1 tablet by mouth three times a day related to GENERALIZED ANXIETY DISORDER -Start Date- 12/5/15

12/5/15 at 5:00 p.m.- Nurses's initials and the #9 (9= Other/See Nurse Notes)
12/6/15 at 9:00 a.m.- Nurses's initials and the #9
12/6/15 at 1:00 p.m.- Nurses's initials and the #9
12/6/15 at 5:00 p.m.- Nurses's initials and the #9
12/7/15 at 9:00 a.m. Nurses's initials and a check (check=administered)
The following scheduled doses until Resident #22's Discharge on 12/11/15 were administered.

Resident #22's Nurse's Notes were reviewed and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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documented in part, as follows:

12/5/15 at 5:01 p.m. Type: Medication Administration Note
Note Text: no script.

12/5/15 at 5:02 p.m. Type: Medication Administration Note
Note Text: unavailable awaiting from pharmacy.

12/6/15 at 9:25 a.m. Type: Medication Administration Note
Note Text: need script.

12/6/15 at 12:16 p.m. Type: Medication Administration Note
Note Text: awaiting script.

12/6/15 at 5:40 p.m. Type: Medication Administration Note
Note Text: not on hand, awaiting for MD for script.

12/6/15 at 6:52 p.m. Type: Medication Administration Note
Note Text: stated only taken as needed.

Resident #22 was admitted to the facility on 12/5/15 at 12:29 p.m. and the physician ordered Xanax dated 12/5/15 at 1:16 p.m. was not received in the facility until 12/7/15 at 12:09 a.m. approximately 35 hours later.

On 5/19/16 at 10:15 a.m. and interview was conducted with the Director of Nursing (DON). The DON was asked if Xanax was available in the facility emergency stat box and the DON stated "Yes". The DON was asked to explain what happened. The DON stated, "If the

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	495340	A. BUILDING _____ B. WING _____	C 05/19/2016

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pharmacy would have called the doctor and the doctor would have faxed the the script over to the pharmacy for the medication then we would have been allowed to get it out of the emergency stat box and give it to her. We were waiting on the script from the doctor."

On 5/19/16 at 12:30 p.m. during the complaint debriefing with the Administrator, the above information was shared. The Administrator was asked what she would have expected her staff to have done regarding obtaining Resident #22's Xanax and what would be a reasonable timeframe to have obtained the medication. The Administrator stated, " I would expect someone to get in touch with the doctor or the pharmacy to get the prescription so we could administer the medication and I prefer to have resident's medications in the facility the day of their admission."

The facility policy titled "7.0 Medication Shortages/Unavailable Medications" last revised 1/1/13 documented in part, as follows:

Procedure:
1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from pharmacy.

2. If a medication shortage is discovered during normal Pharmacy hours:
2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery.
2.2 If the next available delivery causes delay or

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a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose.

3. If a medication shortage is discovered after normal Pharmacy hours:

3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply.
3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action.

4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions.

7. If Facility nurse is unable to obtain a response from the attending Physician/Prescriber in a timely manner, Facility nurse should notify the nursing supervisor and contact Facility's Medical Director for orders/direction, making sure to explain the circumstances of the medication shortage.

Prior to exit no further information was provided by the facility.

This is a Complaint Deficiency

*Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and

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indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

**Hypertension: a common disorder that is a known cardiovascular disease risk factor, characterized by elevated blood pressure over normal values of 120/80 mm Hg (milligrams of mercury) in an adult.

***Congestive Heart Failure: an abnormal condition that reflects impaired cardiac pumping an the ability to maintain the metabolic needs of the body.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

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F 000	Initial Comments An unannounced biennial State Licensure Inspection and (Medicare/Medicaid standard survey) was conducted 05/17/16 through 05/19/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Five (5) complaints were investigated during the survey. The census in this 102 bed facility was 100 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 17) and 5 closed record reviews (Residents 18 through 22).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12-VAC 5-371-220. Nursing Services. A. Each Nursing facility shall implement written care policies and procedures which support an active program of nursing care directed toward assisting all residents to achieve outcomes consistent with their highest level of self care and independence. Cross reference F332 12 VAC 5-371-300 (A/B). Please Cross-Reference to F-425 The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:	F 001		

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