DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER - LYNCHBURG	2200 LANDOVER PLACE LYNCHBURG, VA 24501

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/19/19 through 2/21/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/19/19 through 02/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 118 certified bed facility was 98 at the time of the survey. The survey sample consisted of 20 current Resident reviews and 3 closed record reviews.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623	F623 Notice requirements before Transfer /Discharge I Corrective Action Resident #76 #93. Social Worker notified the local ombudsman office of discharges of resident # 76 and resident #93. Social Worker was immediately educated on regulation. II Identification All residents residing in the facility that discharges or transfers have the potential to be affected by this practice. The Social Worker will complete a 100% audit of the discharges and transfers over the past 30 days and the local Ombudsman office will be notified.	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annette Admin

TITLE: ADMINISTRATOR

(X6) DATE: 3/8/19

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(6) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623	III Systemic Changes The administrator/designee will educate the Social Worker on the current regulation. Social Worker will provide the list of discharges to the Administrator that was submitted to the local Ombudsman office for review. IV Monitoring The Social Worker/Designee will audit all discharges and transfers weekly for 4 weeks and monthly x 2 months to ensure notifications have been made. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee and will determine the need for additional audits and/or action plans. V Date of Compliance 4/5/2019	

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F 623	Continued From page 2 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide written notification of a hospital transfer for two of 23 residents in the survey sample: Residents #76 and # 93. 1. Resident #76 was discharged to hospital and the facility did not notify the Ombudsman or the responsible party (RP) in writing. 2. Resident #93 was discharged to hospital and the facility did not notify the Ombudsman or the responsible party (RP) in writing. The Findings Include: 1. Resident #76 was admitted to the facility on 8/19/11 with the most readmission on 1/24/19. Diagnoses for Resident #76 included: Diabetes, end stage renal disease receiving dialysis, hypotension, sleep apnea, and morbid obesity. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/27/19. Resident #76 was assessed as being cognitively intact with a score of 15 of 15. Resident #76 was her own responsible person (RP). On 2/20/19 Resident #76's medical record indicated that Resident #76 was admitted to the hospital on 1/7/19 with a primary diagnoses of C-Diff colitis with hypotension, returned back to the facility on 1/17/19, discharged to the hospital again on 1/21/19 with primary diagnoses of hypotension secondary to adrenal insufficiency and returned back to the facility on 1/24/19.	F 623		

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F 623	Continued From page 4 On 02/20/19 at 10:56 AM, the social worker (SW) was interviewed concerning notifying the Ombudsman and Resident #76 in writing of the discharges in January 2019. The SW verbalized that she had not been sending written notification to Ombudsman or Representative regarding being discharged to the hospital. The SW verbalized that she does send notification to the Ombudsman of someone's discharge if the Resident is not going to return to the facility, but was unaware that she had to notify in writing if a Resident was being discharged to a hospital. On 02/20/19 03:35 PM the above information was presented to the director of nursing and the administrator. No other information was presented prior to exit conference on 2/21/19. 2. Resident #93 was admitted to the facility on 1/17/19 with a readmission on 1/30/19. Diagnoses for Resident #93 included: cerebrovascular disease (CVA), chronic kidney disease, muscle weakness, hypertension, difficulty walking, fracture of right femur, and routine healing of fracture. The most recent minimum data set (MDS) dated 2/13/19 assessed Resident #93 as being cognitively intact with a score of 15 for daily decision making. Resident #93 was interviewed on 02/19/19 regarding her stay at the facility. Resident #93 stated she was doing better and making slow progress since her hospital stay last month. Resident #93 stated she originally was admitted to the facility for therapy after falling and breaking her hip at home, however she had a small stroke and was admitted to the hospital where she had	F 623		

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F 623	Continued From page 5 surgery for stent placement and wore a heart monitor for a few days. Resident #93's clinical record was reviewed on 02/19/19 at 2:15 p.m. A nursing progress note dated 01/23/19 with a timestamp of 14:53 p.m. (2:53 p.m.) documented "Patient admitted to hospital." On 02/20/19 at 10:56 a.m., the social worker (OS #1) was interviewed concerning notifying the State Ombudsman's office regarding Resident #93 being discharged to the hospital on 01/23/19. OS #1 stated she did not notify the State Ombudsman's office of Resident #93's discharge to the hospital because she was not aware she was supposed to. OS #1 stated she had not been notifying the State Ombudsman's office when any resident was discharged to the hospital. These findings were reviewed with the administrator, director of nursing and corporate staff during a meeting on 02/20/19 at 3:34 p.m.	F 623		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed for one of 23 residents in the survey sample (Resident # 101) to ensure an accurate Minimum Data Set. Resident # 101, who was discharged home, was identified on a Discharge - Return Not Anticipated Minimum Data Set as having been discharged to an acute	F 641	f641 Accuracy of assessments Corrective Action I The MDS for resident #101was corrected to indicate that he was discharged home.	

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F 641	Continued From page 6 hospital. The findings were: Resident # 101 in the survey sample, a 36 year-old male, was admitted to the facility on 12/31/18 with diagnoses that included anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, benign prostatic hyperplasia, renal insufficiency, diabetes mellitus, hyperlipidemia, osteomyelitis, difficulty walking, Vitamin D deficiency, morbid obesity, dilated cardiomyopathy, generalized muscle weakness, acquired absence of left great toe and other left toes. According to the resident's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/7/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Review of Resident # 101's closed Electronic Health Record (EHR) revealed the following Progress (Nurses) Notes entry: 1/18/2019 - 1608 - "Resident discharged at this time. All belongings taken with resident. All scripts taken with resident. SUN transport to transport home...." Also included in the resident's EHR was an Ombudsman Discharge Notification, dated 1/18/19, that indicated the resident was discharged back to the community because the resident's discharge goals were met. According to a Discharge - Return Not Anticipated MDS, with an ARD of 1/18/19, the resident was identified at Item A2100 Discharge Status, as	F 641	II **Identification** All residents in the facility that have care plans have the potential to be affected by this practice. The MDS Coordinator audited all discharges for the past 30 days to ensure that each MDS was coded properly. III **Systematic Changes** The Administrator/ designee educated the MDS Coordinator on completion of MDS accuracy. IV **Monitoring** The MDS Coordinator/Designee will conduct audits on all discharged residents weekly x4 then monthly x2 for accurate completion. Data collected will be forwarded to Quality Assurance and Improvement Committee and will determine the need for additional audits and/ or action plans. V **Date of Compliance** **4/5/2019**	

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F 641	Continued From page 7 having been discharged to an acute hospital. On 2/20/19 at 1:30 p.m., RN # 1 (Registered Nurse), the MDS Coordinator, was interviewed regarding the entry at item A2100 on the Discharge - Return Not Anticipated MDS. After checking her records, RN # 1 stated the entry at A2100, acute hospital, was incorrect. The findings were reviewed during a meeting at 3:30 p.m. on 2/20/19 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 641		
F 645 SS=B	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645	F 645- PASSAR Screening I. Correction A level 1 PASSAR was obtained on resident #62 II Identification All residents of the facility have the potential to be affected by this practice. A 100% audit has been conducted of all current residents to ensure that level 1 PASSAR's have been completed. III System change The Director of Nursing educated the Social Worker and Admissions Director on ensuring that every resident has been screened for a level 1 PASSAR upon admission.	

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F 645	Continued From page 8 authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an	F 645	IV **Monitoring** The Social Worker/Designee will audit all new admissions weekly x4 then monthly x2 to ensure the medical records reflect a level 1 PASSAR. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee and will determine the need for additional audits and/or action plans. V **Date of Compliance** **4/5/19**	

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F 645	Continued From page 9 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to ensure a PASARR (Pre-Admission Screening and Resident Review) was completed for one of 23 resident's, Resident #62. Resident #62 did not have a PASARR screening when admitted to the facility. The Findings Include: Resident #62 admitted to the facility on 10/31/11. The most recent MDS was a quarterly assessment with ARD (Assessment Reference Date) of 1/22/19. Diagnoses for Resident #62 included: Diabetes, dementia with lewy bodies, Parkinson's disease, depression, malignant neoplasm of uterus. Resident #62 had a cognitive score of 11 indicating moderately cognitively intact. On 2/19/19 Resident #62's medical record was reviewed and did not evidence that A PASSAR had been completed by the facility. On 2/20/19 at 9:45, AM the social worker along with the admissions director was asked to present evidence that a PASARR was completed at the time of admission. The social worker present a "Psycho-social Assessment" that was faxed to the facility by PACE (Programs for all Inclusive Care for the Elderly) and was faxed stamped and dated 11/25/2011. The assessment	F 645		

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F 645	Continued From page 10 itself did not evidence when the assessment was completed. On 2/20/19 at 10:58 AM, the social worker was interviewed again about the pre-screen PASARR that should be completed upon admission. The social worker verbalized that Resident #82 was admitted through PACE and PACE should have completed the pre-screen and would call PACE and ask to have it faxed to the facility. On 02/20/19 at 3:35 PM, the above information was presented to the administrator, director of nursing and regional vice president. On 2/21/19 at 9:00 AM, the social worker was again asked for evidence of the PASARR. The social worker verbalized that the facility was still trying to get a copy from PACE. On 02/21/19 at 10:05 AM, during a meeting with the administrator, director of nursing and regional vice president, the regional vice president stated that there was a misunderstanding with PACE in regards to completing a PASARR and therefore it was never completed, indicating only a psych-social assessment was done at the time of admission. No other information was presented prior to exit conference. on 2/21/19.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656	F 656- Development of Comprehensive Care Plans I Correction The care plan for resident #24 was updated immediately to reflect a plan of care for Gastroparesis.	

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F 656	Continued From page 11 resident rights set forth at §483.10(c)(2) and §483.10(o)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and	F 656	II Identification All residents with Gastroparesis have the potential to be effected by this practice. The facility conducted a 100 % audit of all residents with the diagnosis of Gastroparesis to ensure a comprehensive care plan is in place. III System changes The Director of Nursing / Designee will educate the Interdisciplinary Team on the development and implementation of individualized care plans. IV Monitoring Random audits for comprehensive care plan development and implementation will be completed by the MDS Coordinator/Designee weekly x4 weeks and monthly x2. Data collected will be reported to Quality Assurance and Improvement Committee and will determine the need for additional audits and/or action plans. V Date of Compliance 4/5/19	

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F 656	Continued From page 12	F 656		

clinical record review, the facility staff failed to ensure a CCP (comprehensive care plan) was developed and implemented for one of 23 residents in the survey sample, Resident #24.

Findings include:

Resident #24 was admitted to the facility originally on 05/27/18. The resident was readmitted on 06/07/18 and again on 08/17/18, with the most recent readmission being on 01/31/19. Diagnoses for Resident #24 included, but were not limited to: high blood pressure, DM (diabetic mellitus), depression, ESRD (end stage renal disease) dependent upon hemodialysis, right above the knee amputation, constipation and gastroparesis.

A quarterly MDS (minimum data set) assessment dated 12/01/18 was reviewed. The MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as requiring extensive assistance for toileting with at least one person physical assistance. The resident was also assessed as "always" continent of bowel. This MDS additionally assessed the resident as receiving a diuretic during the previous, 7 day look back period, and as receiving hemodialysis while a resident.

The most recent full MDS assessment with CAAS (care area assessment summary), was a 5 day admission assessment dated 06/03/18. This MDS was reviewed for CAAS information. The resident triggered on this MDS for, but not limited to: urinary, nutrition and dehydration. Further review of this MDS for dehydration, documented

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that the resident had vomiting on 05/29/18 per nursing notes and this was a causative trigger.

An interview was conducted on 02/19/19 at 2:52 PM with Resident #24. The resident stated that she went to the hospital January 28th because she was sick and stated that she was vomiting and couldn't stop. The resident stated that she was eventually sent to the hospital, where she was admitted and was told [by hospital staff] that she was impacted. The resident stated that this isn't the first time that she has had problems with her bowels and it seems to be an ongoing problem. The resident was readmitted to the facility on 01/31/19.

Resident #24's clinical record documented that the resident had a new diagnoses of gastroparesis, as of 01/31/19. The resident's hospital records were reviewed and documented that it was originally thought that the resident had a gastrointestinal virus [nausea/vomiting], but after further evaluation, concluded the resident was impacted.

A GI (gastroenterologist) consult dated 01/18/19 was reviewed and documented that the resident was examined and the resident had complained of constipation and associated nausea with abdominal cramping. The GI consult documented, "...patient previously doing well on Linzess, but [was] discontinued in 08/2018-unsure why this was done...Constipation- will restart Linzess 290 mcg [micrograms] daily after dialysis continue Miralax as well after dialysis...Nausea - feel this is secondary to constipation..."

A review of Resident 24's medical record

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F 656	Continued From page 14	F 656		

revealed the resident went to hospital on 08/02/18 for chest pain while at dialysis. The resident was admitted to the hospital and then readmitted to the facility on 08/07/18. On 08/08/18 the resident's hand written POS (physician's order set) documented orders for Linzess 290 mcg once daily. A nursing note documented the resident was trying to have a BM (bowel movement) on 08/11/18, but was having difficulty. On 08/14/18 the resident was at dialysis and complained of a headache with slurred speech per documentation. The resident was again sent to ER. The resident was readmitted to the facility on 08/17/18. The Linzess was not on the POS dated 08/17/18. The resident was discharged to the hospital and upon return the medication was not restarted. There was no discontinuation order and no documentation regarding the discontinuation of the Linzess. The physician's orders were signed, but did not include the medication Linzess.

Further review of the resident's record revealed that the resident was administered Linzess, Miralax and Colace daily from 01/18/19 through 01/28/19. It was documented that the resident had bowel movements during this time.

The resident's current CCP (comprehensive care plan) was reviewed. The CCP documented, "...Pain medication...Monitor for altered mental status...constipation..." No other information was found regarding the resident's constipation, gastroparesis, nausea/vomiting, medications used for constipation or any information regarding this resident's history of bowel problems.

On 02/20/19 at 3:37 PM, an end of day meeting was held with the DON (director of nursing),

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F 656	Continued From page 15 administrator, corporate nurse and regional director. They were asked for the most current CCP on Resident #24. On 02/21/19 at 8:08 AM, the DON presented a CCP for Resident #24 and stated that this was the most current care plan. The DON stated that the resident did not have a care plan for constipation, and agreed that the resident should have triggered and should have a care plan for constipation. The DON then stated, that she updated the care plan this morning, but not for constipation. The DON was asked why this resident's medication (Linzess) for constipation had been discontinued in August of 2018. On 02/21/19 at 8:20 AM, the DON returned and stated that the resident had constipation listed under the pain section of the CCP. The DON then stated that the resident "doesn't actually have a diagnoses of constipation." The DON then stated that the resident went to the hospital in August and was readmitted, and when the resident came back, the medication was not on the admission orders and "we go by the hospital" admission orders. The DON was made aware of the resident's history from the interview with the resident, as well as documentation in the resident's clinical record did evidence that the resident had constipation issues. The DON was made aware that the resident did have a current diagnosis of constipation, as well as gastroparesis and had been seen by GI for concerns. No further information and/or documentation was presented prior to the exit conference on 02/21/19 at 10:45 AM, to evidence the facility staff developed and implemented a CCP for this	F 656		

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F 656	Continued From page 16 resident for constipation and gastroparesis.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to ensure a date was placed on opened medication and was readily available for use on one of 2 units. An opened multidose vial of Lantus (insulin) without a date was readily available for use on the	F 761	F-761 Label/Store Drugs and Biologicals I Correction The bottle of undated insulin was discarded immediately. II Identification All residents receiving medication have the potential of being affected by this practice. A 100% audit was conducted of med-carts, med rooms and refrigerators. No additional bottles of undated insulin were found. III System Change The Director of Nursing / Designee will educate the licensed nurses on labeling, dating, storing and discarding drugs and biologicals. IV Monitoring Director of Nursing or Designee will audit medication rooms, med carts and refrigerators to assure proper dating and labeling are in place. These audits will be conducted weekly x 4 weeks and monthly x2. The results of the audits will be reported to the Quality Assurance and Performance Improvement Committee and will determine the need for additional audits and/or action plans.	

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F 761	Continued From page 17 second floor unit. The Findings Include: On 02/20/19 at 2:39 PM, storage of medications and biological's was observed on the second floor. A multidose vial of Lantus insulin was observed opened and without an open date in the refrigerator available for distribution. There was a sticker on the bottle to indicate that the Lantus would expire after 28 days of being opened. The Director of nursing (DON) was in the medication room at the time of the observation. When asked about the medication without an open date, the DON verbalized that the Lantus should have been dated with an open date and should not be in the refrigerator. On 02/20/19 at 3:35 PM, the above information was brought to the attention of the director of nursing (DON) and administrator during an end of day staff meeting. The administrator was asked for a policy regarding storing medications. On 02/21/19 the facility presented a policy regarding storage and expiration dates of drugs and biological's and read in part "[...] Nursing staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." No other information regarding this concern was provided prior to exit conference on 2/21/19.	F 761	V Date of Compliance 4/5/2019	
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services	F 791	F-791 Routine Emergency Dental Services	

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F 791	Continued From page 18 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for	F 791	I **Correction** Resident #55 went to dental appointment and received services on 2/22/19. II **Identification** All residents that require dental care have potential to be affected by this practice. A review will be completed to determine if any additional residents require consult. III **System changes** The Director of Nursing / designee will educate the Interdisciplinary Team regarding dental assessments and how to arrange dental consults. IV **Monitoring** The Director of Nursing/Designee will audit appointments and dental consultations weekly x 4 and monthly x2. The audits will be reported to the Quality Assurance and Performance Improvement Committee and determine the need for any additional audits and/or action plans. V **Date of compliance** 4/5/2019	

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F 791	Continued From page 19 reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to obtain dental services for Resident # 55. Resident # 55 had broken, carious bottom teeth, and had no dental care since admission. Findings include: Resident # 55 was admitted to the facility 3/17/18 with diagnoses to include but not limited to: anemia, high blood pressure, anxiety and depression. The most recent MDS (minimum data set) was a quarterly review dated 1/15/19. Resident # 55 was coded as cognitively intact with a total summary score of 13 out of 15. The clinical record was reviewed 2/20/19 beginning at 10:30 a.m. Nurses' notes documented the following: 11/30/18 "Complaint of tooth pain. Tylenol 325 mg 2 tabs administered. Effective" 12/5/18 "...tooth pain. 2 Tylenol 325 mg administered with effectiveness." 12/17/18 "(name of practice) called regarding an appointment for tooth extraction...daughter aware and will transport....." 1/14/19 "scheduled for oral surgery 1/23/19..." 1/18/19 "complain of tooth pain...Tylenol 325 mg 2 tabs administered. Effective." 1/20/19 "tooth pain.....Tylenol administered with relief...." 1/23/19 "Dental appt. canceled by daughter. She	F 791		

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F 791	Continued From page 20 states she will let us know when appt. (appointment) is rescheduled." 1/25/19 "...complaint of tooth pain...given Tylenol...daughter canceled dental appt. in (city) stating she could not drive her car that far...spoke with unit manager concerning this..." 1/28/19 "Tylenol for tooth pain...." 2/6/19 "Tylenol for tooth pain..." 2/8/19 "Tylenol for tooth pain...pain rated at 6..." On 2/20/19 the unit manager, RN (registered nurse) # 2 was interviewed about the resident's tooth pain, and if there was any further information about the appointment that was to have been rescheduled by the daughter. RN # 2 was read the entry from 1/25/19 that he was made aware of the canceled appointment. He stated "Who made that note? I do know that the daughter was supposed to call back when the appointment was rescheduled...she has not called yet. No one locally will see our patient's, they have to go out of the area." RN # 2 was then asked since the daughter had voiced an issue with her car, why the facility ahd not gotten the appointment rescheduled and transportation arranged? RN # 2 stated "The social worker should have been involved to help with those arrangements." On 2/20/19 at 11:30 a.m. the facility social worker was interviewed. She stated "Well, I know I had quite a time to get that first appointment scheduled; I had arranged transportation but then the daughter said she would take her...I was not made aware the appointment did not happen...the unit manager is the one who would have reported to me so I could get everything rescheduled..." On 2/20/19 at 1:50 p.m. during an interview	F 791		

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Resident # 55 she stated "Yes, these bottom teeth have been bothering me quite a while...do you think you can help me get a ride to get them taken care of? They're [teeth] in a bad fix." The resident was then asked if the bottom teeth could be observed. She stated "yes" and of the 4 remaining teeth on the bottom, one was broken, two were blackened, and two other teeth were in poor condition overall.

On 2/21/19 at 7:45 a.m. the care plan was reviewed. A care plan for dental problems was dated as initiated on 1/30/19. The care plan included focus/goals and interventions related to the resident's tooth pain. The care plan did not include any information about the canceled appointment. There were few interventions other than to "refer to dentist/hygienist for evaluation/recommendations re: denture realignment, new fitting, teeth pulled, repair of carious teeth." Other interventions included administering medication for tooth pain and reporting any changes in oral cavity.

On 2/21/19 at 8:09 a.m. RN # 3, who was an MDS coordinator, was asked about the care plan, and the date initiated as the resident began complaining of tooth pain in November 2018. RN # 3 stated "In November when the tooth pain was identified they could have/should have initiated the care plan at that time. On previous assessments, there had not been any dental issues identified. When the most recent quarterly review was done, that's when the tooth pain and issues were identified so that's when I initiated the care plan..."

On 2/21/19 at approximately 9:00 a.m. the social worker informed this surveyor a dentist appt. for

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F 791	Continued From page 22 Resident # 55 had been made "for in the morning." On 2/21/19 during a meeting with facility staff the administrator, DON (director of nursing), and regional nurse consultant were made aware of the above findings. No further information was provided prior to the exit conference.	F 791		

PRINTED: 03/11/2019
FORM APPROVED

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 02/19/2019 through 02/21/2019. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated. The census in this 118 bed facility was 98 at the time of the survey. The survey sample consisted of 20 current Resident reviews and three (3) closed record reviews.	F 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements. This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12VAC5-371-140. (D) (2.) Please cross-reference to F623 12VAC5-371-250. (G) Please cross-reference to F656 12VAC5-371-250. (A.) Please cross-reference to F641 12VAC5-371-300. (A.) Please cross-reference to F761 12VAC5-371-320. (A.) Please cross-reference to F791	F 001	12VAC5-371-140. (D) (2.) Please cross-reference to F623 12VAC5-371-250. (G) Please cross-reference to F656 12VAC5-371-250. (A.) Please cross-reference to F641 12VAC5-371-300. (A.) Please cross-reference to F761 12VAC5-371-320. (A.) Please cross-reference to F791	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Connelly ADMINISTRATOR — TITLE — (X6) DATE: 3/8/19