STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING ______ B. WING ______	R-C **09/05/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	**776 OAK GROVE RD PO BOX 1277** **CHESAPEAKE, VA 23320**

(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
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 07/16/19 through 07/19/19, was conducted 09/04/19 through 09/05/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #101 through #107, #111 through #116 and #118) and 4 closed record reviews (Residents #108 through #110 and #117).	{F 000}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	{F 755}		9/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/23/2019

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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{F 755}	Continued From page 1 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure medications were available for one of 18 residents in the survey sample, Resident #105. The findings include: Resident #105 was admitted to the facility on 8/30/19 with diagnoses that included but were not limited to, fracture of left and right femur, high blood pressure, acute pain. A comprehensive assessment had not yet been completed. Resident #105 was documented as being alert and oriented x 4 in his clinical record. Review of Resident #105's clinical record revealed that he was admitted to the facility on 8/30/19 at 12:45 p.m. Review of Resident #105's August 2019 POS (physician order summary) revealed the following	{F 755}	1. Resident #105 did not receive ordered doses of Gabapentin on 8/31/2019. No immediate correction is possible. The MD was notified of the omission on 9/5/2019. No new orders were given. 2. All new admission's to the Great Bridge Pavilion are at risk. 3. The licensed nursing staff who omitted the doses of Gabapentin have been formally counseled on 9/20/2019. All licensed nursing staff are receiving 1:1 training and re-education regarding processes for Medication Administration and Medication Labeling/Storage. Each session requires a signed affirmation statement acknowledging understanding and compliance with expectations, and disciplinary proceedings with possible termination as a consequence of non-compliance. 4. The Clinical Manager, or designee, will monitor new admissions to the Great Bridge Pavilion through first dosing of	

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{F 755}	Continued From page 2 order: "Neurontin (1)(gabapentin) 600 mg three times daily...Diabetic Nephropathy (2)." Review of Resident #105's MAR (Medication Administration Record) revealed he missed three doses of his Gabapentin 600 mg (milligrams) on 8/31/19 (the next day) at 12:00 a.m., 8 a.m. and 4 p.m. The note sheets on the MAR documented the following for all three administration times: "Not administered Med (medication) Not Available." Review of Resident #105's nursing notes failed to evidence a reason why his Gabapentin was not available. Resident #105's clinical record failed to evidence any uncontrolled pain or negative outcome related to his missed doses of Gabapentin. Review of the facility's STAT box list revealed that Gabapentin 600 mg was in the STAT box. On 9/5/19 at 9:23 a.m., interviews were attempted with the nurses who documented: "Not administered" on the MAR on 8/31/19. These two nurses could not be reached for an interview. On 9/5/19 at 9:46 a.m., an interview was conducted with RN (Registered Nurse) #3, the unit manager. When asked the process of ensuring newly admitted residents receive their scheduled medications, RN #3 stated that nurses should enter the orders into the computer system, verify orders with the physician and fax any hard scripts to pharmacy for medications that require hard scripts. RN #3 stated that if a medication was needed right away, she would call the pharmacy to have them STAT the medication or pull the medication from the emergency STAT	{F 755}	medication orders x 8 weeks to assure compliance and sustainability of the re-education and expectations. This process improvement plan will be reviewed monthly by QAPI to provide additional oversight and/or revise the POC as needed.	

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{F 755}	Continued From page 3	{F 755}		

box. When asked if Gabapentin 600 mg was in the STAT box, RN #3 stated that she didn't think so. RN #3 also stated that Gabapentin required a hard script as of August 1st 2019. When asked if a resident was admitted on 8/30/19 in the afternoon if she would expect the resident to get all their medications for the next day (8/31/19), RN #3 stated that she would expect that resident to receive all of their medications for the next day. RN #3 stated that if the medication was not available when the nurse went to administer the medication, she would expect the nurse to check the STAT box to see if the medication was available, or call pharmacy to have the medication sent STAT. RN #3 stated that she would also expect the nurse document in the clinical record why a medication was not available. RN #3 stated that she was not sure what happened with Resident #105's Gabapentin.

On 9/5/19 at 9:54 p.m., an interview was conducted with Resident #105. When asked if he received all his medications when he first arrived to the facility, Resident #105 stated that he was not sure. When asked if he was in pain when he had first arrived to the facility due to his Gabapentin being unavailable, Resident #105 stated that he was always in some type of pain whether it be nerve pain or gas pain. Resident #105 could not recall if he had an increase in pain on 8/31/19.

On 9/5/19 at 11:05 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #1 stated that they did have a policy regarding the above concerns but had an instruction sheet for the nurses on ordering medications. The following was

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{F 755}	Continued From page 4 documented: "Before 8 PM M-F or Before 4 PM on Sat-Sun: Enter the order in vision. It must be activated, not draft format. Orders will be processed same day and delivered on next run. If still no meds, call Pharmacy. After 10 PM M-F or after 5 PM Sat-Sun: Call back up pharmacy (pharmacy number) If still no meds: Call on call pharmacist: (number). No Medication orders should go unfilled and no patient should ever have to wait for pain meds." (1) Neurontin (gabapentin)- recommended for chronic neuropathic pain. This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Peripheral-Neuropathy-Fact-Sheet. (2) Diabetic Nephropathy-is a type of kidney disease caused by diabetes. This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/diabetic-kidney-disease.	{F 755}		
{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	{F 761}		9/30/19

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{F 761}	Continued From page 5 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, staff interviews and facility documentation review, the facility failed to ensure medications were labeled and stored in accordance with currently accepted professional principles on 2 out of 4 units. The findings included: 1. The facility staff failed to ensure one bottle of Aspirin 81 mg (milligrams) was removed from the medication cart once expired. On 09/04/19 at approximately 4:00 p.m., an inspection of the medication cart on Unit (2) was conducted with Licensed Practical Nurse (LPN) #2. During the inspection of the medication cart was an open bottle of Aspirin 81 mg with an expiration date of 08/19. The surveyor asked LPN #2, "Should the bottle of Aspirin still be stored inside the medication cart after the expiration time has lapsed" she replied, "No, I am going to remove the Aspirin as soon as you are finished inspecting the cart." An interview was conducted with Director of	{F 761}	1. The medications that had expired (Aspirin 81 mg and Humalog Insulin vials), were discarded on 9/5/2019. The medication cart on Unit 3 was locked immediately once noted. LPN #1 placed the open bottle of Tylenol inside the medication cart once noted. The liquid Ativan was discarded on 9/5/2019. Replacement medication was obtained and stored in the refrigerator on 9/5/2019. All medication storage areas were stripped and searched for any expired medications in stock. All medications have been discarded as of 9/13/2019. 2. All residents are at risk from this deficient practice. 3. All licensed nursing staff are receiving 1:1 training and re-education regarding processes for Medication Administration and Medication Labeling/Storage. Each session requires a signed affirmation statement acknowledging understanding and compliance with expectations, and disciplinary proceedings with possible	

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{F 761}	Continued From page 6 Nursing (DON) on 09/04/19 at approximately 5:05 p.m. She said expired medication should be removed from the medication cart immediately. 2. The facility staff failed to ensure medication cart was locked when not in direct site on 1 of 4 units (Unit 3). On 09/04/19 at approximately 4:50 p.m., the surveyor observed the medication cart on Unit 3 (middle cart) unlocked and left unattended when not in direct site of the nurse. The medication nurse, Licensed Practical Nurse #1 arrived to the medication cart at approximately 4:53 p.m. The surveyor asked LPN #1, if the medication cart should be locked when not in her direct view, she replied, "I should have locked my cart before I went into the resident's room." On the same day at approximately 5:05 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, "Before the nurse left her medication cart, she should have made sure it was locked." 3. The facility staff failed to ensure medication (Tylenol) was stored in a secured location, accessible to designated staff only. On 09/04/19 at approximately 4:50 p.m., the surveyor observed an open bottle of Tylenol (325 mg) sitting on top of the medication cart unattended. The medication nurse, Licensed Practical Nurse (LPN) #1 arrived to the medication cart at approximately 4:53 p.m. The surveyor asked LPN #1, if she was aware, an open bottle of Tylenol was left on top of her medication cart unattended. She replied, "I meant to put the Tylenol inside the cart before I went into the resident's room." She removed the Tylenol, placed it inside the cart then locked her cart. On the same day at approximately 5:05 p.m., an interview was conducted with the Director of	{F 761}	termination as a consequence of non-compliance. 4. The staff nurse is now being assigned cart checks daily to assure medications are labeled and stored appropriately, and that all expired medications are discarded. The Nursing Leadership team (DON, SDC and Clinical Managers), or designee, will monitor every medication storage area 5 times weekly x 2 weeks, weekly x 4 weeks, every other week x 4 weeks, and monthly thereafter to assure the carts are locked, expired medications are discarded, medications are sored appropriately, and no medications are stored on top of the medication cart. This process improvement plan will be reviewed monthly by QAPI to provide additional oversight and/or revise the POC as needed.	

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{F 761}	Continued From page 7 Nursing (DON). The DON stated, "Medications should never be left on top of the cart unattended. The nurse should make sure all medication are stored inside the cart before leaving the medication cart." 4. The facility staff failed to ensure liquid Ativan was stored as recommended by the manufactures guidelines on 2 of 4 units (Units 2 and 3) and failed to ensure a multi dose vial of insulin (Humalog R) was dated once opened. On 09/04/19 at approximately 4:00 p.m., this surveyor inspected the medication cart on Unit (2) with License Practical Nurse (LPN) #2. Stored inside the narcotic controlled box was a multi dose vial of liquid Ativan. The surveyor asked, "Should liquid Ativan be stored on the medication cart" she replied, "No, liquid Ativan should be stored in the refrigerator." On the same day at approximately 4:53 p.m., this surveyor inspected the medication cart on Unit (3) with Licensed Practical Nurse (LPN) #1. Stored inside the narcotic controlled box was two multi dose vials of liquid Ativan and an open vial of Humalog insulin not dated when opened. The surveyor asked, "Should liquid Ativan be stored on the medication cart" she replied, "Liquid Ativan is stored in the refrigerator." The LPN said insulin should always be dated once open. The surveyor asked, "How long is insulin good for once open" she replied, "30 days." An interview was conducted with Director of Nursing (DON) on 09/04/19 at approximately 5:05 p.m. The DON said liquid Ativan is stored in the medication refrigerator and insulin is good for 28 days after opening. The DON stated, "The nurse is to date the insulin once open along with their initials."	{F 761}		

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{F 761}	Continued From page 8	{F 761}		

The Administrator and Director of Nursing was informed of the finding during a briefing on 09/05/19 at approximately 11:15 a.m. The facility staff did not present any further information about the findings.

-The facility's policy titled Life Care - Storage of Medications (Last Revision 2/15/18).
Policy Statement: Medications, treatments, and biological are stored safely, securely, and properly following manufacture's recommendations or facility policy. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reorder from the pharmacy if a current order exists.

The facility's policy titled Life Care - Medication Administration (Revision date: 04/10/19.)
-Purpose: Safe and accurate administration of medications.

General Guidelines include but not limited to:
-The medication Cart is to be locked at all times, unless in direct view of the license nurse.

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{F 761}	Continued From page 9 Life Care - Medication: Expiration Dates: (Last Reviewed date: 01/17/17.) -Policy statement: All "Timed-Dated" medications have an expiration date printed on the container. Refer to the Manufacture Product Information or Contact Dispensing Pharmacy. -Expiration Dates (Suggested): -Once opened; all insulin kept in the refrigerator in the medication cart expires 28 days after opening. -Other bulk medications expire on manufacture regardless of opening.	{F 761}		