PRINTED: 03/01/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION		SURVEY PLETED
		495419	B. WING			1	C (25/2024
NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	25/2021
				,	7090 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSING HO)ME		1	MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(XS) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	Preparedness COVID conducted on 2/23/2′ substantial compliant Requirement for Long INITIAL COMMENTS An unannounced Mestandard survey was 2/25/21. One complaunsubstantiated with investigated during the	edicare/Medicaid abbreviated conducted 2/23/21 through aint (VA00050373-	F	000	This Plan of Correction constitute written allegation of compliance is deficiencies cited. Submission of Plan of Correction is not an admist that a deficiency exists or that one cited correctly. This Plan of Corr	or the this sion was	
F 550 SS=D	The census in this 62 at the time of the sun consisted of 17 curre three closed record in Resident Rights/Exer	are Requirements. certified bed facility was 42 yey. The survey sample nt resident reviews and eviews. cise of Rights	F	550	submitted to meet requirements established by state and federal la Covenant Woods is committed to sustaining compliance with regula		
	self-determination, ar access to persons an outside the facility, in this section. §483.10(a)(1) A facili	ght to a dignified existence, and communication with and a services inside and cluding those specified in the treat each resident			RECEIVED MAR 1 2 2021		
	promotes maintenand her quality of life, rec- individuality. The faci promote the rights of	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and the resident.			VDHVOLC		
LABORATORY	DIRECTOR'S OR PROVIDED	UPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4fW411

Facility ID: VA0416

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11.909

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
	·						С	
		495419	B. WNG			02/	25/2021	
	ROVIDER OR SUPPLIER IT WOODS NURSING HO)ME			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	access to quality care severity of condition, or must establish and may practices regarding the provision of services or residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit \$483.10(b)(1) The fact resident can exercise interference, coercion from the facility. \$483.10(b)(2) The resident from the facility in the facil	cility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. Of Rights. right to exercise his or her of the facility and as a citizen sted States. Cility must ensure that the his or her rights without and discrimination, or reprisal sident has the right to be oercion, discrimination, and try in exercising his or her orted by the facility in the rights as required under this is not met as evidenced and, staff interview, facility disclinical record review, it the facility staff failed to oner to maintain and nity for one of 20 residents in esident #1. The facility staff lent #1 was covered during 2/24/21, to promote and	F	550				
	Resident #1 was adm	itted to the facility on						

0611161	TO I OIT WILDION TITLE OF	INCDIONID OF MAIOEO				CIMID IAI	J. 0836-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		495419	B. WING			1	C /25/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	U2.	72072021
				1	090 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSING H	OME		l I	IECHANICSVILLE, VA 23111		
	OUR MADY OT	ATEMENT OF DESIGNATION					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	ix .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	3/30/17 with diagnose to Parkinson's diseas dementia (2), and lac most recent MDS (mi assessment with an A	es including, but not limited	Social Worker who verified that the resident was comfortable being uncovered.		24-Feb-21		
	decisions, having sco BIMS (brief interview coded as requiring the staff for bed mobility,	y impaired for making daily ared 11 out of 15 on the for mental status). She was e extensive assistance of transfers between surfaces, personal hydiene. She was			 All residents at Covenant Wood could potentially be affected. Resident preferences during be will be reflected on their care 	athing	31-Mar-21
	eating, toileting, and personal hygiene. She was coded as totally dependent on staff for bathing. On 2/23/21 at 3:05 p.m., Resident #1 was observed lying on her back in bed. Her bed was				 Nursing staff will be in-service privacy options during the bat process; and how to verify res preferences. 	hing	12-Mar-21
in the lowest position, approximately six inch above the floor. Fall mats were visible on bo sides of her bed. An attempt was made to interview Resident #1, however Resident #1 voice was very soft and hoarse, and her wor were unintelligible.		nats were visible on both attempt was made to I, however Resident #1's nd hoarse, and her words			4. Unit manager or designee will care plans for preferences. The Plan team will review preferer each CP meeting. DON or deswill do random checks with residents to make sure that	e Care	31-Mar-21
	seated in a shower chair was reclined. The waist-height of CNA (#2 in the shower chair bathing the resident. Resident #1 was lean	te bathroom. She was nair, and the back of the ne resident was elevated to certified nursing assistant) r. CNA #2 was observed Observation revealed hing to the right in the chair,			preferences are followed. Exceptions will be reported to QAPI.		
	CNA #2 left Resident	incovered. At 10:06 a.m., #1's room and closed the ervation revealed CNA #2			RECEIV		
	returned to Resident	#1's room in approximately ne was entering the room,			MAR 1 2 2	021	
	CNA #2 was asked if #1 while the CNA had	anyone was with Resident I been gone. CNA #2 stated, no one was assisting her to			VDHVQL	.C	.461

PRINTED: 03/01/2021 FORM APPROVED

CENTER	S FOR WEDICARE &	MEDICAID SERVICES				OMB I	<u> 10. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		495419	B. WING				C 2/25/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSING HO	OME S			CHANICSVILLE, VA 23111		
244.45	CHIMMADY OT	ATEMENT OF DEFICIENCIES					-
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	Continued From page	. 2			9		
1 000			F:	550			18
	bathe Resident #1, ar						10
		#1 while she was alone in hower chair. CNA #2 stated,	ļ				
		prush her teeth. I needed to					
		CNA #2 was accompanied					
	back into Resident #1						
		in the elevated shower chair,					
		ht, with her back reclined.					
	Resident #1 was total			ĺ			
		., 4.10010100.			***		
	On 2/24/21 at 10:29 a	ı.m CNA #2 was					
	interviewed. When as						
	Resident #1 alone in t	the shower chair, CNA					1
	#2stated, "She was ha	aving a bowel movement so					1 1
		out for a minute." When					
	1	idered covering Resident					
		or when she left the room,					
		t. CNA #2 stated, "She					
		rivate bathroom." CNA #2					
		a need for Resident #1 to					
		ked if being left completely h of time added to Resident					
		ing treated with dignity, CNA					
		ot speak for the resident.					1 1
	The second secon						
	On 2/24/21 at 2:13 p.r	m., LPN (licensed practical					
	· ·	wed. She stated she had					
	already been informed						
		NA #2. LPN #2 stated,		1			
		ing, [Resident #1] wanted to					
	-	a bowel movement." When					1
		should have been covered			aras	TAN APPROPRI	1
		or while CNA #2 left her			RECE	IVED	
		e room, LPN #2 stated she				A	
	could not say for sure				MAR 1	2 2021	i
	Resident #1 had been	•			\$ 450 a.s.	4	
	manner when CNA #2				VDH	OLC	
	Resident #1 complete						
	stated she could not s	ay for sure decause	1				

OFILE	CO I OIN MILLDIOMINE OF	MEDICAID SERVICES				OMP M	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		495419	B. WING		<u></u>		C 25/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
COVENAI	NT WOODS NURSING HO)ME			090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	#1, the unit manager, asked if Resident #1 seither during her bath completely alone in the "Yes. She [Resident # covered." She stated cover the part of the best #1 stated, "That is [nuthing to do. She should There is nothing else Resident #1's dignity she was left totally under the part of Resident #1's dignity. A review of Resident revealed no information resident with dignity.	m., RN (registered nurse) was interviewed. When should have been covered or when CNA #2 left her be bathroom, RN #1 stated, the basic nursing practice is to body not being bathed. RN busing 101. That is a basic did have been covered up. I can say." RN #1 stated was not preserved when covered by CNA #2. #1's care plan dated 4/11/19 on related to treating the	F	550			
*	staff member) #1, the the director of nursing concerns. A review of the facility Resident Dignity," rev Facility] ensures that	m., ASM (administrative administrator, and ASM #2, were informed of these policy, "Preservation of ealed, in part: "[Name of each resident is treated with and that each resident is					*
	assisted in maintainin well-being and self-es No further information (1) "Parkinson's disea	g and enhancing his or her teem." was provided prior to exit. se (PD) is a type of	;		RECEIV MAR 1 2 20		
	in the brain don't prod chemical called dopar				VDHVOL		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVE COMPLETED	Υ
		495419	B. WING			С	
NAME OF PI	ROVIDER OR SUPPLIER	400110	12: 11:10	STREET ADDRESS, C	ITY, STATE, ZIP CODE	02/25/20	21
COVENAN	IT WOODS NURSING HO	ME		7090 COVENANT W MECHANICSVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	ADER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA DEFICIENCY)	COMP	X6) PLETION ATE
F 689 SS=D	(2) "Dementia is a grabrain function. This or It affects memory, thin and behavior." This in website https://medlineplus.go	ation is taken from the ov/parkinsonsdisease.html. adual and permanent loss of occurs with certain diseases. aking, language, judgment, formation is taken from the ov/ency/article/000746.htm. ards/Supervision/Devices (2)	F	i 3.			
	§483.25(d)(1) The resas free of accident has free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation document review, and was determined that the care in a safe manner the survey sample, Refailed to ensure Reside supervision during ba #1, who was assesse in the bathroom unattercollined in an elevated. The findings include:	sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced in, staff interview, facility of clinical record review, it he facility failed to provide for one of 20 residents in esident #1. The facility staff lent #1 was provide thing on 2/24/21. Resident d as at risk for falls, was left ended, while seated and d shower chair.			RECEIVE MAR 1 2 202 VDH/OLG	1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTR		(X3) DATE	E SURVEY PLETED
		495419					С
NAME OF D	BOMBER OF CURRINER	450415	B. WING			02	/25/2021
	ROVIDER OR SUPPLIER NT WOODS NURSING HO	PME		7090 COV	DDRESS, CITY, STATE, ZIP CODE ENANT WOODS DRIVE IICSVILLE, VA 23111	<u> </u>	
(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)	E ATE	(X5) COMPLETION DATE
F 689	to Parkinson's disease dementia (2), and lack most recent MDS (min assessment with an A date) of 11/19/20, Res being moderately cog daily decisions, having BIMS (brief interview coded as requiring the staff for bed mobility, to	e (1), disorientation, c of coordination. On the nimum data set), a quarterly RD (assessment reference sident #1 was coded as nitively impaired for making g scored 11 out of 15 on the for mental status). She was e extensive assistance of transfers between surfaces,	Fé	F 6 1. 2. 3.	Resident #1 was interviewed be Social Worker who verified the resident asked to be left alone. All residents at Covenant Wood could potentially be affected.	ods ed on	24-Feb-21 12-Mar-21
	eating, toileting, and personal hygiene. She was coded as being totally dependent on staff for bathing. On 2/23/21 at 3:05 p.m., Resident #1 was observed lying on her back in bed. Her bed was				preference options. Staff will always remain with resident in shower unless resident is Independent in all ADL's.	1	
	fall mats were visible. interview Resident #1. voice was very soft an were unintelligible.	On either side of her bed, An attempt was made to However, Resident #1's d hoarse, and her words		4.	DON or designee will randomle check residents with "needs assistance" with shower on the care plan to verify staff remain with resident twice weekly for weeks then periodically. Excessill be reported to QAPI.	ir s two	08-Apr-21
	chair was reclined. The waist-height of CNA (c #2 in the shower chair, bathing the resident. T the right in the chair, a uncovered. The survey	e bathroom. She was air, and the back of the a resident was elevated to ertified nursing assistant) CNA #2 was observed the resident was leaning to and was completely					
	closed the door behind 60-90 seconds, CNA #	her. In approximately 2 returned to Resident #1's			RECEIVE)	
	was asked if anyone w the CNA had been gon	ring the room, CNA #2 as with Resident #1 while e. CNA #2 stated: "No." was assisting her to bathe			VDHVOLC		

NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME!)	AND PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	
The state of the s	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPUTED TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROPERTY OF THE PROPERT	PREFIX (EACH DEF
Resident #1, and that no one was supervising Resident #1, and that no one was supervising Resident #1, and that no one was supervising Resident #1 while she was alone in the bathroom in the shower chair. She stated: "I'm getting ready to brush her teeth. I needed to get a cup for water." The surveyor accompanied CNA #2 back into Resident #1 is private bathroom. Resident #1 was still in the elevated shower chair, leaning over to the right, with her back reclined. Resident #1 was totally uncovered. A review of Resident #1's clinical record revealed a physician's order dated 12/20/20. The order documented: "Floor matscheck three times daily." A review of Resident #1's care plan dated 4/11/19, and updated 12/16 20, revealed: "At risk for falls R/T (related to) Parkinson's. Fall mats beside bed when in bed." On 2/24/21 at 10:29 a.m., CNA #2 was interviewed. When asked why she had left Resident #1 alone in the shower chair, CNA #2 stated, "She was having a bowel movement so she asked me to step out for a minute." When asked if Resident #1 was able to support herself in the chair, CNA #2 stated, "No. She carn't support herself. That's why it's good the chair leans back." When asked if Resident #1 was safe to be left alone in an elevated shower chair without a staff member within sight or sound range, CNA #2 stated she thought so. On 2/24/21 at 2:13 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she had already been informed of the questions the surveyor had asked GNA #2. LPN #2 stated, "From my understanding, [Resident #1] wanted to	Resident #1, ar Resident #1 wh in the shower of to brush her tee water." The sur into Resident # was still in the e over to the right #1 was totally use A review of Resaphysician's or documented: "F daily." A review of Resaphysici

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100410	D. 141110	5	STREET ADDRESS, CITY, STATE, ZIP CODE	02	/25/2021	
COVENA	NT WOODS NURSING HO			7	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 689	#1 completely alone we shower chair, LPN #2 have stayed by the bachair is safe enough for he asked why Resident # position and why the non both sides of the boshe [Resident #1] falls On 2/24/21 at 2:46 p.n. #1, the unit manager, asked if Resident #1 wan elevated shower chwas not safe. RN #1 sissue. She should have was not safe." On 2/24/21 at 4:00 p.n. staff member) #1, the the director of nursing, concerns. A review of the facility Supervision of Resident resident-oriented appropriately and accident haresidentsResident sucomponent of the system type and frequency determined by the indirects and identified have the component of the system. The type and identified have the component of the system of the facility safety and accident has residentsResident sucomponent of the system of	practice to leave Resident while she was in an elevated stated, "I probably would throom door. I feel like that or her. That chair has arms. Her to be left alone." When it's bed is kept at the lowest esident's floor has fall mats ed, LPN #2 stated, "In case it." In., RN (registered nurse) was interviewed. When was safe to be left alone in hair, she stated the resident stated, "That was a safety been within eyesight. It In., ASM (administrative administrator, and ASM #2, were informed of these policy, "Safety and has," revealed, in part: "Our bach to safety addresses szards for individual upervision is a core ems approach to safety. Ye of resident supervision is widual resident's assessed azards in the environment." Was provided prior to exit. We (PD) is a type of	F	689				
	movement disorder. It in the brain don't produ	happens when nerve cells ice enough of a brain						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DA1	IO. 0938-039 FE SURVEY APLETED
	495419	B. WING			C
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME		701	REET ADDRESS, CITY, STATE, ZIP CODE 80 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111		2/25/2021
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
continued From page 9 chemical called dopamine. So genetic, but most cases do not families." This information is to website https://medlineplus.gov/parkir (2) "Dementia is a gradual ambrain function. This occurs with the and behavior." This information website https://medlineplus.gov/ency/soccurs/fracheostomy Cases (CFR(s): 483.25(i) § 483.25(i) Respiratory care, including care and trached and trached suctioning, it care, consistent with profession practice, the comprehensive practice, the comprehen	ot seem to run in aken from the asonsdisease.html. d permanent loss of the certain diseases. Inguage, judgment, on is taken from the article/000746.htm. In and Suctioning and Suctioning. Including all suctioning. In resident who ing tracheostomy is provided such inal standards of erson-centered and preferences, in the article and clinical ed, that the facility espiratory is for one of 20 and preferences are sevidenced and clinical ed, that the facility espiratory is for one of 20 and the facility espirat	F 695			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR		(X3) DATE	E SURVEY PLETED
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	ROVIDER OR SUPPLIER			7090 COV	DDRESS, CITY, STATE, ZIP CODE ENANT WOODS DRIVE	<u> 02</u>	/25/2021
(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
	diagnoses that include chronic obstructive purchronic respiratory fail. Resident #30's most reset), a quarterly assess (assessment reference Resident #30 as scoria assessment for mentar of 0 - 15, 11- being more making daily decisions documented as received at the facility, in Section On 2/23/21 at approximaterview was conducted their room. Observation revealed a rolling standard housing a BIPAP (posimachine (4). Tubing with the machine connecting strap in the basket. The uncovered in the basket and head strap. When Resident #30 stated the when sleeping for their the mask was cared for the nursing staff applied took it off in the morning basket. Resident #30 streeall seeing staff clear a bag.	nitted to the facility with ad but were not limited to Imonary disease (1), ure (2) and pneumonia (3). ecent MDS (minimum data sment with an ARD edate) of 1/27/2021, codeding a 11 on the staff it status (BIMS) of a score oderately impaired for a. Resident #30 was ing oxygen while a resident in O of the assessment. mately 12:40 p.m. an ed with Resident #30 in on of Resident #30 in on of Resident #30's room did with attached basket tive airway pressure) was observed attached to g a facemask with head he facemask was observed et wrapped in the tubing a asked about the machine, at they used it at night of the code of the mask at night and g and placed it back in the stated that it was stored in the mask and or put it in tated that it was stored in ine as observed.	F	2.	BIPAP tubing and face mask is resident #30 was cleaned and in a bag. All residents with respiratory is could potentially be affected, audit of residents did not identiany other issues.	placed needs An tify on ding o	25-Feb-21 12-Mar-21 08-Apr-21
		made on 2/23/21 at 3:10 m. and 2/25/21 at 9:15					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE	SURVEY PLETED
		495419	B. WING			1	C 13513034
	ROVIDER OR SUPPLIER	OME		7090	EET ADDRESS, CITY, STATE, ZIP CODE 0 COVENANT WOODS DRIVE CHANICSVILLE, VA 23111	1 02	/25/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 695	a.m. revealed the sar The physician's order documented in part it - "Home trilogy (bransettings. Do not touc Settings are already is at night only. Order Date: 2/17/202 Weekly" The comprehensive of dated 11/22/2019 doc Resident #30] has pobreathing related to: 0 pneumonia, COPD ex (Current). Effective Dunder "Interventions" Trilogy machine at lordered" On 2/25/21 at approximaterview was conducted nurse) #6. Lespiratory equipment when not in use, and changed weekly. When the time the sage is the purpose in the sage in a bag. LPN nurses normally hand removal of Resident # because they only wo #6 stated that the purpose in the bag was to prevent.	rs for Resident #30 he following: hd of BIPAP machine) h home trilogy machine. In place. Home trilogy used Date: 2/17/2021." r tank. Refill water tank. hd. Frequency: Two Times care plan for Resident #30 cumented in part, "[Name of tential for difficulty in COPD, H/O (history of) kacerbation, Status: Active Date: 11/22/2019-Present." h, it documented in part, "HS (hour of sleep) as imately 9:30 a.m., an atted with LPN (licensed LPN #6 stated that any the was stored in a plastic bag the bag was dated and len asked about the mask ogy machine, LPN #6 stated from the mask but they be an ed once a week and #6 stated that the night shift lied the application and #30's trilogy machine one it during the night. LPN pose of storing the mask in the dust from getting on it and	F	695	RECEIVE MAR 1 2 202 VDHVOLC	D	
		#6 made an observation of machine with the mask			DINOLO	,	

OFILE	O I OIL MEDIONILE G	MICDIONID OFILAIOFO				CIAID IAC	<u>J. 0830-038 I</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/ŞUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING				C /25/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				70	090 COVENANT WOODS DRIVE		
COVENAN	IT WOODS NURSING HO)ME		N	MECHANICSVILLE, VA 23111		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		0/0
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I	BE	(X6) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	3	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
			-}		DETICIENCY)		
F 695	Cantinued From page	- 42	_	205			
F 085	Continued From page			695			
		ket at 9:35 a.m. and stated					
		have been stored in a bag		i			
,		N #6 stated that they were ask or replace it			W		
		when not in use and report					
	it to the unit manager						
		•			OC.		
	The facility policy "De	partmental (Respiratory					
		o of Infection, Level 1 (one)",	1				
		Purpose, The purpose of					1
		uide prevention of infection					
	·	ratory therapy tasks and					
	equipment, including and staff" The poli	ventilators, among residents					
20		age of masks used for					
		wever it documented in part,					
	-	nula and tubing used PRN					
		tic bag when not in use"					
		imately 9:30 a.m., ASM	- 01				
ſ	(administrative staff n		Ì				
	were made aware of	M #2, the director of nursing					
	Welle Illade awale of	ille illidaigs.					
	No further information	n was provided prior to exit.					
,	References:						
	Chronic obstructive	e pulmonary disease					
	(COPD)						
		t difficult to breath that can			25		
		preath. This information was			**		
	obtained from the wel]
	nups://www.nim.nin.g	ov/medlineplus/copd.html.					
	2. Chronic respirator	v failure					
		ygen passes from your lungs					
		information was obtained					1
	from the website:	<u></u>					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495419	B. WNG					C / 25/2021	
	ROVIDER OR SUPPLIER)ME	i i	7090 C	T ADDRESS, CITY, STATE, ZIP CODE COVENANT WOODS DRIVE IANICSVILLE, VA 23111			72 5 /2021	
(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)	IOULD B	_	(X8) COMPLETION DATE	
F 695	ilure.html. 3. Pneumonia An infection in one or germs, such as bacter	ov/medlineplus/respiratoryfa both of the lungs. Many ria, viruses, and fungi, can	F	695					
	Positive airway pressumachine to pump air u airway of the lungs. The open during sleep. The CPAP (continuous posprevents episodes of a the breathing in people apnea and other	airway collapse that block e with obstructive sleep thing problems. This				243			
		v/ency/article/001916.htm v, Report irregular, Act On	F7	756	ė.				
		men Review. g regimen of each resident east once a month by a	v						
	§483.45(c)(2) This rev of the resident's medic	iew must include a review cal chart.					12		
	irregularities to the atte facility's medical direct and these reports mus	armacist must report any conding physician and the cor and director of nursing, at be acted upon. e, but are not limited to, any			72)				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495419	B. WING.]	C /25/2021
COVENAM (X4) ID		ATEMENT OF DEFICIENCIES	ID	70 M	TREET ADDRESS, CITY, STATE, ZIP CODE 1990 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION	-	Q45)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 756	drug that meets the cr (d) of this section for a (ii) Any irregularities n during this review must separate, written repo attending physician ar director and director of minimum, the resident	ontinued From page 14 rug that meets the criteria set forth in paragraph l) of this section for an unnecessary drug.) Any irregularities noted by the pharmacist uring this review must be documented on a separate, written report that is sent to the tending physician and the facility's medical rector and director of nursing and lists, at a inimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.		756	 Medication Regimen Review residents #6 and #30 were sub to the physician for review. All residents could potentially affected. An audit of all Medication Regimen reviews was completed. 	be ication	24-Feb-21
	and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.				 The pharmacy consultant will provide a copy of Medication Regimen Reviews before leav campus and will email a copy facility. 	ing	03-Mar-21
	§483.45(c)(5) The fact maintain policies and drug regimen review to limited to, time frames the process and steps when he or she identifications are urgent action. This REQUIREMENT by: Based on staff interview and clinical record review the facility staff failed of the pharmacy medical.	cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take ifies an irregularity that in to protect the resident. The is not met as evidenced item, facility document review view it was determined that to act in a timely manner on the strong ample, Residents			4. DON or designee to check all Medication Regimen Reviews monthly for MD review timely two months, then random chec monthly and exceptions report QAPI.	s y for cks	08-Apr-21
	#6 and #30.	• •			RECEIVE	D	
	completed on 1/17/21 a gradual dose reduct and hypnotic medicati discovered by the faci				VDHVOLC		

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING				С
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 1090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	1 02	25/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Resident #30. Resider regimen review was or recommendations to order for Klonopin (see was not reviewed by tof 2021. The findings include: 1. Resident #6's medicompleted on 1/17/21 a gradual dose reduct and hypnotic medicati discovered by the faci presented to the physilater. Resident #6 was admidiagnoses that include atrial fibrillation (1), indepressive disorder (3). Resident #6's most reset), a quarterly asses (assessment reference coded Resident #6, as assessment for mental of 0 - 15, 15- being codaily decisions. Secti	illed to act in a timely ion regimen review for ent #30's medication completed on 9/17/2020 with evaluate the as needed dative medication) which the physician until January dication regimen review was with recommendations for cion of the antidepressant ions which were not dilty in their email or iclan for action until 39 days days ditted to the facility with ed but were not limited to somnia (2) and major 3). cent MDS (minimum data as ment with an ARD edate) of 11/27/2020, a scoring a 15 on the staff all status (BIMS) of a score ignitively intact for making on N documented Resident pressant and hypnotic so for Resident #6 e following:	F	756	RECEIVE MAR 1 2 2021 VDI-VOLC		

PRINTED: 03/01/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDED IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPLE CONSTRUCTION DING			O. 0938-039° E SURVEY IPLETED
		495419	B. WING			١ ,	C
	PROVIDER OR SUPPLIER NT WOODS NURSING HO	DME		70	STREET ADDRESS, CITY, STATE, ZIP CODE 1990 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	1. 02	2/25/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	(Current), Description (antidepressant) 60 m delayed release 1 (on 11/21/2020" - "Order Date: 11/22/2 (Current), Description: tablet 1 time daily. St "Order Date: 2/25/20 (Current), Description: delayed release 1 time 2/25/2021" - "Order Date: 2/25/20 Description: Ambien 5 Start Date: 2/25/2021 The eMAR (electronic record) for Resident # Medications" documer the Duloxetine 60mg of daily each day as order the Duloxetine 60mg e 2/1/21 through 2/25/20 each day in February froders dated 2/25/202 of the Duloxetine and from part, "1/17/2021 15:: This patient's medical in has been reviewed. M GDR (gradual dose recomprehensive care	E Duloxetine ag (milligram) capsule, e) time daily. Start Date: 2020, Status Active E Ambien (hypnotic) 10 mg art Date: 11/22/2020" 2021, Status: Active E Duloxetine 30 mg capsule, e daily. Start Date: 2021, Status Active (Current), amg tablet 1 time daily. 2021, Status Active (Current), amg tablet 1 time daily. 2021, medication administration 6 dated "January 2021 ated Resident #6 received daily and Ambien 10mg ared above. 2021 medication administration 6 dated "February 2021 ated Resident #6 received and the Ambien 10mg and the Ambien 10mg from 2/1/21 through and the Ambien 10mg from 2/1/21 through arther documented the new 1 for the reduced dosages Ambien. Resident #6 documented 51 (3:51 p.m.) Pharmacy. record/medication regimen D (medical doctor) notes-	F 2	756			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED	
	#8	495419	B. WING			C 02/25/2021	
	ROVIDER OR SUPPLIER)ME	.	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		02/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 756	#6] is at risk for side of psychoactive medicational used to treat/ms behaviors/symptoms: Status: Active (Current "Interventions", it documedication regiment in Status: Active (Current Status: Activ	effects related to use of ion: -sedatives/hypnotics ychoactive medications are anage following insomnia, depressed mood. In:" Under umented in part, "Conduct eview no less than monthly. In:" I mately 4:00 p.m., a request diministrative staff member) ising for evidence of regimen reviews and any gradual dose reductions for mately 8:00 a.m., ASM #2 ents having pharmacy eviews completed in a containing Resident #6. It wo documents titled "Note In/Prescriber" with a MRR eview) date of 1/17/2021 documents requested the enditory date of 1/17/2021 documents requested the enditory date of 1/17/2021 documents requested the enditory and dated by the latest and forms and for enditory and the enditory of "Agree" and1) Reduce dose to the long PO (by mouth) QD Physician/Prescriber cument referencing the long once daily documented	F	RECEIVE MAR 1 2 202 VDHVOL	EID 21		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/01/2021 FORM APPROVED

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		495419	B. WNG				C 02/25/2021
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		02/25/2021
COLENA	VT WAARA WIRAWA II				0 COVENANT WOODS DRIVE		
COVERA	NT WOODS NURSING H	DME			CHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 756	documented, "1) R Ambien 5mg PO QD On 2/25/21 at 9:40 a. conducted with ASM: ASM #2 stated that th monthly and sends th them by email. ASM the reviews and place for them to review and after the physician review and the physician's responsake any changes to needed. When asked between the date of th physician review, ASM medication reviews se normally reviewed the	educe dose to the following" m., an interview was #2, the director of nursing. The pharmacist comes in the medication reviews to #2 stated that they print out to them in the doctor's book the sign. ASM #2 stated that wiews them the nurses fax the pharmacy and medication orders as a labout the length of time the MRR and the date of the M #2 stated that the sent from the pharmacy were a next day. When asked y for review within thirty	F	756			
	department was working the pharmacy emails of folder. ASM #2 stated documents for Reside yesterday after this surand printed them out of that the pharmacist has reviews were not on to January and had reserviews in January of was when they initially problem, and they had September through De 2021. The facility policy "Druster in the pharmacy of the	ne residents charts back in in them a bulk of pharmacy 2021. ASM #2 stated that it discovered the email I received the reviews for exember 2020 in January of g Regimen gime Review, Developed:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY
		OMPLEIED
495419 B. WING		С
NAME OF PROVIDED OR SURPLUED		02/25/2021
STREET ADDRESS, CITY, STATE, ZIP CODE		
COVENANT WOODS NURSING HOME 7090 COVENANT WOODS DRIVE		
MECHANICSVILLE, VA 23111		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
F 756 Continued From page 19 Procedures/Requirementa) The consulting pharmacist will provide copy of recommendations to the attending physician, medical director, and director of nursing within five (5) working days of completion of the reviewb) The director of nursing or designee will review the recommendations and the attending physicians will be contacted for review and response. c) If the attending physician does not respond within thirty (30) days, the medical director will be asked to review the recommendations and/or contact the attending physician" On 2/25/21 at approximately 11:10 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 2. Insomnia A common elsep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both. As a result, you may get too little sleep or have poor-quality sleep. You may not feel refreshed when you wake up. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/insomnia.ht ml.		

	TMENT OF HEALTH AN				.4	FOR	D: 03/01/202 M APPROVEI O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495419	B. WING				C /25/2021
COVENAI	PROVIDER OR SUPPLIER NT WOODS NURSING HO			70	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111		23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	3. Major depressive of Major depression is a when feelings of sadn frustration get in the wiperiod of time. It also of works. This information website: https://medlineplus.go 2. The facility staff fall manner on a medicated Resident #30. Reside regimen review was correcommendations to e order for Klonopin (see was not reviewed by the formation of the facility of the formation of the formation of the facility of the formation of the facility staff fall manner on a medicated regimen review was correcommendations to e order for Klonopin (see was not reviewed by the formation of the facility of the fac	disorder mood disorder. It occurs ess, loss, anger, or ray of your life over a long changes how your body on was obtained from the v/ency/article/000945.htm. ded to act in a timely on regimen review for nt #30's medication ompleted on 9/17/2020 with evaluate the as needed dative medication) which he physician until January nitted to the facility with d but were not limited to	F 7	758			

set), a quarterly assessment with an ARD (assessment reference date) of 1/27/2021, coded Resident #30 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions. Section N documented

Resident #30 receiving antipsychotic,

The physician's orders for Resident #30 documented the following in part,
- "...Oder Date: 8/10/202. Discontinued 11/27/2020. Klonopin 0.5 mg (milligram) tablet

a resident at the facility.

antidepressant and antianxiety medications while

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING				C 25/2021
	ROVIDER OR SUPPLIER)ME		70	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111		20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	PRN (as needed)G daily as needed in ad "Order Date: 11/2 2/7/2021. Klonopin 0 (maximum) 1(one) do time daily at (bedtime scheduled dose" - "Clonazepam (genemg (milligram) tablet (0.25 mg nightly as ne Date: 2/7/2021" The eMAR (electronic record) for Resident # Medications and Febrailed to evidence any administrations 1/1/21 The progress notes for in part, - "8/20/2020 14:25 (2 duration for prn (as ne (recommendation) to chart reviewed. This was conducted within the COVID-19 outbree - "9/17/2020 18:26 (6 Medication regimen h (medical doctor) note "10/21/2020 11:28 (patient's medical record been reviewed. NN (monitoring" - "11/17/2020 12:12 (This patient's medical has been reviewed. NThe comprehensive compared to the comprehensive comprehe	dition to scheduled dose" 27/2020. Discontinued 27/2020. Discontinued 28 and the session of	F	756	RECEIVED MAR 1 2 2021 VDH/OLC		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING] ' '			(X3) DATE SURVEY COMPLETED	
		495419	B. WING_			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		/25/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 756	use of psychoactive manipsychotics -antide Psychoactive medicate treat/manage following Status: Active (Currer Under "Interventions" Conduct medication than monthly. Effective On 2/24/21 at approximate was made to ASM (as #2, the director of numpharmacy medication recommendations for Resident #30. On 2/25/21 at approximate provided lists of reside medication regimen	sk for side effects related to mediation [sic]: epressants -antianxiety, stons are being used to g behaviors/symptoms: at), Effective: 11/22/2019" it documented in part, " a regimen review no less ye: 1/22/2019" Imately 4:00 p.m., a request siministrative staff member) sing for evidence of regimen reviews and any gradual dose reductions for mately 8:00 a.m., ASM #2 ents having pharmacy eviews completed in ye containing Resident #30. If a document titled "Note to prescriber" with a MRR review) date of 9/17/2020 as "Note to Attending for Resident #30 dated and in part, "Please PRN: Klonopin and select by Continue for 14 days, 2) due to the following:" mented in the response" section, " arder, [Signature of 1/21 (January 2021)"	F	756			
		e pharmacist comes in					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		SURVEY PLETED
		495419	B. WING			l .	C /25/2021
	ROVIDER OR SUPPLIER	OME		7090	EET ADDRESS, CITY, STATE, ZIP CODE D COVENANT WOODS DRIVE CHANICSVILLE, VA 23111		20/2021
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
F 756	them by email. ASM the reviews and place for them to review an after the physician rethe physician's response any changes to needed. When asked between the date of the physician review, ASI medication reviews sometication reviews when the department was work the pharmacy emails folder. ASM #2 stated "Note to Attending Phy 17/2020 from the ply pharmacist had reserviews were not on the January and had reserviews were not on the January and they had september through Department through Department through Department was when they initially problem, and they had september through Department of the pharmacist had reserviews in January of was when they initially problem, and they had september through Department of the pharmacist had reserviews in January of was when they initially problem, and they had september through Department and ASI were made aware of the physician and ASI were made aware of the physician reviews and ph	we medication reviews to #2 stated that they print out the them in the doctor's book d sign. ASM #2 stated that views them the nurses fax has to the pharmacy and medication orders as d about the length of time he MRR and the date of the M #2 stated that the ent from the pharmacy were enext day. When asked by for review within thirty that they were having emails and that their IT ting to resolve the issue of going to their junk mail d that they had received the hysician/Prescriber' dated harmacy in January after the at it to them. ASM #2 stated and observed that their the residents charts back in ent them a bulk of pharmacy 12021. ASM #2 stated that by discovered the email d received the reviews for feecember 2020 in January of mately 11:10 a.m., ASM member) #1, the M #2, the director of nursing	F	756			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495419	B. WING			C 02/25/2021	
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758 SS=D	lead to shortness of b obtained from the wel https://www.nlm.nih.g 2. Dementia A loss of brain functio diseases. It affects mijudgment, and behaviobtained from the wel https://medlineplus.gc 3. Major depressive of Major depression is a when feelings of sadr frustration get in the viperiod of time. It also works. This information website: https://medlineplus.gc Free from Unnec Psy CFR(s): 483.45(c)(3)(c) §483.45(e) Psychotro	t difficult to breath that can breath. This information was baite: pov/medlineplus/copd.html. In that occurs with certain emory, thinking, language, ior. This information was baite: pov/ency/article/000739.htm. disorder a mood disorder. It occurs ness, loss, anger, or way of your life over a long changes how your body ion was obtained from the pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm. pov/ency/article/000945.htm.		756			
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	hotropic drug is any drug that associated with mental vior. These drugs include, drugs in the following ensive assessment of a nust ensure that—			RECEIVE MAR 1 2 2021 VDH/OLC	D	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405440	B 14410				С
NAME OF D		495419	B. WING		· · · · · · · · · · · · · · · · · · ·	02	25/2021
	ROVIDER OR SUPPLIER NT WOODS NURSING HO	OME		70	REET ADDRESS, CITY, STATE, ZIP CODE 990 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111	21	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 758	psychotropic drugs ar unless the medication	e 25 Ints who have not used the not given these drugs to is necessary to treat a diagnosed and documented	F :	758	 F 758 Medication Regimen Review for resident #30 was submitted to physician for review. Recommended reduction was authorized. 	or	24-Feb-21
	drugs receive gradual behavioral intervention contraindicated, in an drugs; §483.45(e)(3) Resided psychotropic drugs purpless that medication	effort to discontinue these ints do not receive irsuant to a PRN order i is necessary to treat a indition that is documented			 All residents could potentially affected. An audit of all Medic Regimen Reviews was complet The pharmacy consultant will provide a copy of Medication Regimen Reviews before leaving campus and will email a copy to facility. 	eation ted.	03-Mar-21
	are limited to 14 days. §483.45(e)(5), if the a prescribing practitione appropriate for the PR beyond 14 days, he or rationale in the resider indicate the duration for \$483.45(e)(5) PRN or drugs are limited to 14 renewed unless the apprescribing practitione the appropriateness of This REQUIREMENT by: Based on staff intervitant clinical record reverthe facility staff failed for the prescribing staff failed for the facility staff failed for the prescribing practitione.	or believes that it is th order to be extended or she should document their ont's medical record and or the PRN order. ders for anti-psychotic of days and cannot be stending physician or or evaluates the resident for of that medication. is not met as evidenced ew, facility document review iew it was determined that			4. DON or designee to check all Medication Regimen Reviews monthly for MD review timely two months, then random check monthly and exceptions reporte QAPI.	ks	08-Apr-21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495419	B. WING	<u></u>		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		2/25/2021
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	act in a timely manner pharmacy medication recommendations for the antidepressant and prescribed and administration of the antidepressant and prescribed and administration of the action until 2/24/2. The findings include: Resident #6 was admidiagnoses that include atrial fibrillation (1), in depressive disorder (3)	ions. The facility failed to r on the on 1/17/21 regimen review, with a gradual dose reduction of d hypnotic medications istered to Resident #6. The adual dose reduction not discovered by the r presented to the physician I, a period of 39 days. itted to the facility with ed but were not limited to somnia (2) and major	F 75	58		
	set), a quarterly asses (assessment reference coded Resident #6, as assessment for ments of 0 - 15, 15- being codaily decisions. Secti #6 receiving antidepres medications. The comprehensive codated 11/20/20 docum #6] is at risk for side a psychoactive medicationatidepressants. Psybeing used to treat/ms behaviors/symptoms: Status: Active (Curren "Interventions", it documents	essment with an ARD se date) of 11/27/2020, se scoring a 15 on the staff al status (BIMS) of a score agnitively intact for making on N documented Resident sessant and hypnotic are plan for Resident #6 nented, "[Name of Resident affects related to use of ion: -sedatives/hypnotics //choactive medications are anage following insomnia, depressed mood. at)" Under amented in part, "Conduct eview no less than monthly.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WNG				0
NAME OF P	ROVIDER OR SUPPLIER	780718	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	25/2021
COVENAN	T WOODS NURSING HO	DME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL. 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 758	The physician's order documented the followard of the fol	s for Resident #6 wing in part, 2020, Status: Active : Duloxetine ng (milligram) capsule, e) time daily. Start Date: 2020, Status Active : Ambien (hypnotic) 10 mg art Date: 11/22/2020" 021, Status: Active : Duloxetine 30 mg capsule,	F	758	•)		
	Start Date: 2/25/2021 The eMAR (electronic record) for Resident # Medications" docume the Duloxetine 60mg daily each day as docume the Email of the eMAR (electronic record) for Resident # Medications" docume the Duloxetine 60mg 2/1/21 through 2/25/2 each day in February 2/24/21. The eMAR for orders dated 2/25/20/20 of the Duloxetine and The progress notes for in part, "1/17/2021 15 This patient's medical	e medication administration the dated "January 2021 inted Resident #6 receiving daily and Ambien 10mg cumented above. c medication administration the dated "February 2021 inted Resident #6 received each day in February from 1 and the Ambien 10mg from 2/1/21 through further documented the new 21 for the reduced dosages			RECEIVED MAR 1 2 2021 VDHVOLC		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
- 1		495419	B. WING				C 25/2021
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				1	7090 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSING HO	ME		l a	MECHANICSVILLE, VA 23111		
					RECHARGOVILLE, VA 23111		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	-15.6	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	T	SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
1					DEFICIENCY)		
				_			
F 758	Continued From page	28	F	758			
	GDR (gradual dose re	eduction) requests "		•			
	(3						
	On 2/24/21 at approxi	imately 4:00 p.m., a request	•				
		dministrative staff member)					
	#2, the director of nur	sing for evidence of					
	pharmacy medication	regimen reviews and any]				
		gradual dose reductions for	1				
	Resident #6.						#
		imately 8:00 a.m., ASM #2					
		ents having pharmacy					
	medication regimen n	/ containing Resident #6.					
		two documents titled "Note					
		n/Prescriber" with a MRR					
		review) date of 1/17/2021					
		documents requested the					
	physician evaluate the	duloxetine and Ambien for			202		
	a potential gradual do	se reduction. The				-	
		erved to be signed and				}	
		n 2/24/21, 39 days after the					
	MRR date of 1/17/202				//*		
	"Physician/Prescriber						
		the medication Duloxetine					
	60mg once daily docu	imented a physician ind further documented, "					
		he following Duloxetine					
	l *	QD (every day)" The					
	"Physician/Prescriber						
		the medication Ambien					
	10mg once daily docu	mented a physician			5-10 page -		
	l · –	ind further documented, "			RECEIVE	n l	
	1	he following Ambien 5mg				_	
	PO QD"				MAR 1.2 2001		
	On 0/05/04 -4 0:40	n en intendeur en			MAR 1 2 2021 VDHVOLC		
	On 2/25/21 at 9:40 a.r	n., an interview was #2. ASM #2 stated that the			VOHVOIC		
	pharmacist came in m						
	•	them by email. ASM #2					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495419	B. WNG			l .	С
NAME OF P	ROVIDER OR SUPPLIER	1 4804 18	D. WING	e1	TREET ADDRESS, CITY, STATE, ZIP CODE	02	/25/2021
					990 COVENANT WOODS DRIVE		
COVENAR	NT WOODS NURSING HO	ME		М	ECHANICSVILLE, VA 23111		
(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 758	stated that they print of them in the doctor's be sign. ASM #2 stated reviewed them the nuresponse to the pharmachanges to medication asked about the length of the MRR and the discrete ASM #2 stated that the from the pharmacy were next day. When aske review within thirty dawere having problems their IT department we issue of the pharmacy mail folder. ASM #2 stated that the from the pharmacy mail folder. ASM #2 stated them out for retained them.	out the reviews and place ook for them to review and that after the physician rese would fax their nacy and make any n orders as needed. When the of time between the date ate of the physician review, the medication reviews sent tere normally reviewed the did about the facility policy for tys, ASM #2 stated that they as getting the emails and that the as working to resolve the the emails going to their junk that they had found their junk folder yesterday did requested them and their junk folder yesterday did requested them and the proview. ASM #2 stated that the proviews that their reviews that their reviews that their reviews that the proviews the proviews that the problem, the reviews for September	F	758			
	6/19" documented in p Procedures/Requirem pharmacist will provide to the attending physic director of nursing with completion of the revie nursing or designee we recommendations and will be contacted for re	egime Review, Developed: part, " Specific lent:a) The consulting e copy of recommendations cian, medical director, and hin five (5) working days of ewb) The director of			MAR 1 2 2021 VDHVOLC	Ď	

OG!!!!	910111120101111201	MEDICAID SERVICES			<u> </u>	OWR M	<i>J.</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COM	SURVEY PLETED
		495419	B. WING			1	C / 25/2021
NAME OF PE	ROVIDER OR SUPPLIER			\$1	FREET ADDRESS, CITY, STATE, ZIP CODE		
COVENAN	IT WOODS NURSING HO	ME			990 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X8) COMPLETION DATE
F 758	thirty (30) days, the mator review the recommendate attending physicial on 2/25/21 at approxist (administrative staff madministrator and ASI were made aware of the No further information Reference: 1. Atrial fibrillation A problem with the spendart beat. This information the website:	edical director will be asked endations and/or contact in" mately 11:10 a.m., ASM member) #1, the will #2, the director of nursing the findings.	F	758			
	have trouble falling as both. As a result, you have poor-quality slee refreshed when you w was obtained from the https://www.nlm.nih.goml. 3. Major depressive of Major depression is a when feelings of sadn frustration get in the w period of time. It also works. This information website:	ake up. This information website: pv/medlineplus/insomnia.ht lisorder mood disorder. It occurs		==			

NAME OF PROVIDER OR SUPPLIER COVENANT WOODS HURSING HOME STREET ADDRESS, GITY, STATE, JJP CODE 7080 COVENANT WOODS BRIVE MECHANICSVILLE, VA 2011		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME CA4 ID SUMMARY STATEMENT OF DEFICIENCIES TOP OCCURANT WOODS DRIVE MECHANICSVILLE, VA 23111			495419	B. WING		N.	1	
COVENANT WOODS NURSING HOME (CA) ID SUMMARY SHEEPHENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REBULATORY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 31 F 761 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) 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 staff interview and clinical record	NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	02	25/2021
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 31 F 761 Continued From page 31 F 761 SS=D 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 staff interview and clinical record	COVENAN	NT WOODS NURSING HO	OME					
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) 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 il 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 staff interview and clinical record	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
review, it was determined that the facility staff failed to label medications in one of three medication carts and dispose of biologicals upon expiration date in one of two medication rooms. The facility staff failed to label medications; two white pills were observed in a medication cup in second medication drawer on the Unit C Wing 1.	F 761	Label/Store Drugs and CFR(s): 483.45(g)(h)(s) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the examplicable. §483.45(h) Storage of \$483.45(h)(1) In accordance professional principles appropriate accessory instructions, and the examplicable. §483.45(h)(1) In accordance professional laws, the facility biologicals in locked of temperature controls, personnel to have accessory acceptance of controlled of the Comprehensive Drugs of controlled of the Comprehensive Drugs of controlled of the Comprehensive Drugs of the Comprehensiv	d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be with currently accepted a, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of trug Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the timal and a missing dose can is not met as evidenced ew and clinical record ned that the facility staff tions in one of three dispose of biologicals upon of two medication rooms. to label medications; two ved in a medication cup in	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	<u>). 0938-0391 </u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
£6		495419	B. WING				C 25/2021
COVENAN (X4) ID		PME ATEMENT OF DEFICIENCIES	iD	701 MI	PREET ADDRESS, CITY, STATE, ZIP CODE 90 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 761	upon expiration date. tube feeding formula dressings were obser 1 medication storage in 1 medication storage in 1 medication storage in 1 medication storage in 2/24/21 at 8:30 Al Wing 2 medication cart was upon the medication drawer, two baserved in a 30-milling There was no labeling resident name or date. An interview was concart was upon the medication of the medication of the medication of the medication with LPN #1 stated in the medication of the medicat	to dispose of biologicals Eight bottles of expired and three medication wound ved in the Unit C Wing room. M, an inspection of Unit C rt was conducted. The inlocked and in the second ro white round pills were liter clear medication cup. If of medication, dose, If on the cup. ducted on 2/24/21 at 8:30 Indications were stored Indications we	F	761	 Nurses re-educated on labelin disposing of medications. All residents could potentially affected. Nurses will check medication for any loose, unlabeled medibefore obtaining keys. DON or designee will observe shift twice weekly for two we then weekly for two weeks. Periodic observations will con and exceptions reported to QA 	cart cations e each eeks, htinue, API.	25-Feb-21 01-Mar-21 08-Apr-21
	on 2/1/21. Observation revealed in the second expired dressings. Of alginate (3) dressing 4	on of the wound care cart, d and fourth drawers, three ne Dermaginate calcium 4.25 x 4.25 inches that had d two Mepitel One (4) 3x4	111		MAR 1 2 2021 VDH/OLC	5	D D

CENTER	S FOR MEDICARE &	MICDICAID SERVICES				<u> </u>	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:			CONSTRUCTION		PLETED
		495419	B. WING	····			C 25/2021
NAME OF P	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				701	90 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSING HO	JME		ME	ECHANICSVILLE, VA 23111		-2.
	CUITANADA CT	ATEMENT OF DECIDIENCIES			<u> </u>		
(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 BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 761	AM with LPN #2. Who Osmolite bottles, LPN use them. I don't know When asked who was the tube feeding date nursing's responsibility. When shown the expidressings in the wour "Those should have basked who was responsibility asked who was responsibility the dates and dispose the dates and dispose An interview was comply with RN (register manager. When aske follows for labeling mexpired medications, nursing responsibility the drug name, dose, be administered. Phase declings and central sumake sure there is not delivery. Nursing is mound care cart and is sure they aren't expired ASM (administrative sadministrator and ASI)	ducted on 2/24/21 at 10:07 en shown the expired I #2 stated, "We hardly ever w why we have so many". s responsible for checking s, LPN #2 stated, "It is ty to check the dates". ration dates for the three and care cart, LPN #2 stated, ween disposed of". When whisible for checking the en wound care dressings, ing is responsible to check en of any expired dressings". ducted on 2/24/21 at 2:52 and nurse) #1, the unit end about the process staff endications and removing RN #1 stated, "It is the to label medications with resident name and time to expired supplies prior to exponsible for checking the the tube feedings to make end."	F	761	F 761 1. Nurses re-educated on disposine expired supplies and medication. 2. All residents could potentially affected. 3. Night shift nurses will complet weekly log documenting removall expired supplies and medicated. 4. DON or designee will audit log supplies weekly for three week Periodic checks will continue, a exceptions reported to QAPI RECEIVED MAR 12 2021 VDHVOLC	be a val of ation. g and is. and	25-Feb-21 14-Mar-21 08-Apr-21
)es		ty's policy, "Storage of 4/2007, which documents in I store all drugs and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION O(1) DESCRIPTION NUMBER: AND PLAN OF CORRECTION A BULDING RECOVERANT WOODS NURSING HOME STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS NURSING HOME STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS NURSING HOME STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE FOR COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE FOR COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE FOR COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE FOR COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE CORRECTION STREET ADDRESS, CITY, STATE, 2P CODE CORRECTION STREET ADDRESS, CITY, STATE, 2P CODE TORG COVERANT WOODS DRIVE STREET ADDRESS, CITY, STATE, 2P CODE CORRECTION STREET ADDRESS, CITY, STATE, 2P CODE CORRECTION CORRECTION STREET ADDRESS, CITY, STATE, 2P CODE CORRECTION	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
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