STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/9/21 through 3/11/21. Complaints [VA00050746 and VA00050282, substantiated with deficiencies] were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 88 certified bed facility was 70 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #1 through #3) and one closed record review (Resident #4).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		4/6/21

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

Electronically Signed | 03/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for two of four residents in the survey sample, Residents #1 and #2. The findings include: 1. The facility staff failed to notify the physician (or nurse practitioner) when aspirin 81 mg	F 580	1. Resident #1 and #2 MD/NP was notified of aspirin 81mg and Lyrica not administered as ordered. No new orders given. 2. All residents have the potential to be affected. Quality review of residents' MARs/Medical Record of the past 7 days to be completed by April 2, 2021 to verify proper timely notification of changes to physician or nurse practitioner.	

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F 580	Continued From page 2 (milligrams) was not available for administration to Resident #1 on 2/12/21. Resident #1 was admitted to the facility on 3/3/20. Resident #1's diagnoses included but were not limited to stroke, history of heart attack and chronic kidney disease. Resident #1's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/31/21, coded the resident as being cognitively intact. Review of Resident #1's clinical record revealed a physician's order dated 8/15/20 for aspirin (1) 81 mg- one tablet by mouth one time a day for pvd (peripheral vascular disease) (2). Resident #1's comprehensive care plan dated 2/4/21, documented, "(Resident #1) has Peripheral Vascular Disease (PVD). Give medications for improved blood flow or anticoagulants (blood thinning medication) as ordered..." Review of Resident #1's February 2021 MAR (medication administration record) revealed the physician's order for aspirin 81 mg as documented above and on 2/12/21, the nurse documented the code "9=Other/See Nurse Notes." A nurse's note dated 2/12/21 documented, "not available." Further review of Resident #1's clinical record failed to reveal the physician was notified regarding the unavailability of aspirin for administration to Resident #1 as ordered. On 3/10/21 at 12:09 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the above nurse's note on 2/12/21. LPN #1 stead nurses have to	F 580	3. Licensed nurses to be re-educated by DON/Designee by April 2, 2021 on timely notification of changes to physician or nurse practitioner. Notification of changes will be monitored during clinical meeting to ensure compliance. 4. DON/Designee will conduct quality review of 10% of residents' MARs/medical record to ensure compliance of proper timely notification of changes to physician or nurse practitioner weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6, 2021.	

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F 580	Continued From page 3	F 580		

notify the physician when a medication is not available for administration. LPN #1 stated most over the counter bulk medications are available in the facility supply room and if the medication is not available then someone can go to Walmart and purchase the medication. LPN #1 was made aware of her documentation regarding Resident #1's aspirin on 2/12/21. LPN #1 stated she really did not remember the situation but there was one point when the nurses did not have aspirin 81 mg and that was a bulk house stock medication so staff would have to wait for that order to arrive or someone would have to go to the store and purchase the medication. LPN #1 stated she thought she told someone that there was not aspirin 81 mg available but she did not remember who she told. When asked if she notified the physician or nurse practitioner, LPN #1 stated she thought she did but she was not 100 percent sure.

On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern.

The facility policy titled, "Medication-Oral Administration of" failed to document information regarding physician notification of medication unavailability from the bulk house stock supply.

No further information was presented prior to exit.

References:

(1) "Aspirin therapy is very helpful for people with CAD (coronary artery disease) or a history of stroke." This information was obtained from the website:

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F 580	Continued From page 4	F 580		

https://medlineplus.gov/ency/patientinstructions/000092.htm

(2) "Your peripheral arteries and veins carry blood to and from your arm and leg muscles and the organs in and below your stomach area. PVD may also affect the arteries leading to your head (see Carotid Artery Disease). When PVD affects only the arteries and not the veins, it is called peripheral arterial disease (PAD). The main forms that PVD may take include blood clots (for example, deep vein thrombosis or DVT), swelling (inflammation), or narrowing and blockage of the blood vessels." This information was obtained from the website: https://www.texasheart.org/heart-health/heart-information-center/topics/peripheral-vascular-disease/

2. The facility staff failed to notify the physician (or nurse practitioner) when Lyrica was not available for administration to Resident #2 once on 1/2/21 and twice on 2/12/21.

Resident #2 was admitted to the facility on 3/27/20. Resident #2's diagnoses included but were not limited to paralysis, diabetes and heart failure. Resident #2's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/4/20, coded the resident as being cognitively intact.

Review of Resident #2's clinical record revealed a physician's order dated 8/14/20 for Lyrica (1) - 50 mg- one capsule by mouth three times a day for neuropathic pain.

Resident #2's comprehensive care plan dated 4/9/20 did not document specific information

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F 580	Continued From page 5	F 580		

regarding Lyrica administration.

Review of Resident #2's January 2021 and February 2021 MARs (medication administration records) revealed the above physician's order for Lyrica and on 1/2/21 at 2:00 p.m., and on 2/12/21 at 6:00 a.m. and 2:00 p.m., the nurses documented the code "9=Other/See Nurse Notes."
-A nurse's note dated 1/2/21 at 1:40 p.m. documented, "awaiting arrival from pharmacy."
-A nurse's note dated 2/12/21 at 5:49 a.m. documented, "awaiting delivery."
-A nurse's note dated 2/12/21 at 1:37 p.m. documented, "on order from pharmacy."

Further review of Resident #2's clinical record failed to reveal the physician was notified regarding the unavailability of Lyrica for administration to Resident #2 as ordered, on those above dates/times.

On 3/10/21 at approximately 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who documented the above note on 2/12/21 at 5:49 a.m. LPN #2 stated medications can be refilled through the facility computer system or by calling the pharmacy. LPN #2 stated if a medication is not available for administration, she can check the STAT (immediately or without delay) box (a box containing various medications) and if the medication is not in the STAT box then nurses should call the pharmacy and contact the physician or nurse practitioner. LPN #2 stated she could not recall calling the physician or nurse practitioner regarding Resident #2's Lyrica on 2/12/21.

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F 580	Continued From page 6	F 580		

On 3/10/21 at 12:09 p.m., an interview was conducted with LPN #1, the nurse who documented the above notes on 1/2/21 at 1:40 p.m. and 2/12/21 at 1:37 p.m. LPN #1 stated the pharmacy is slower with medication delivery on the weekends so on Tuesdays, she looks to see how much supply of medications is left and reorders enough medications for administration through the weekend. LPN #1 stated if a medication is not available, then nurses can pull some medications from a facility STAT box but the STAT box does not contain all medications. LPN #1 was made aware of her notes regarding Resident #2's Lyrica on 1/2/21 and 2/12/21. LPN #1 stated she did not recall specific details regarding those dates and could not recall if she called the physician or nurse practitioner.

On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern.

The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "4. If an emergency (medication) delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..."

No further information was presented prior to exit.

Reference:
(1) Lyrica is used to treat pain from damaged nerves. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a605045.html

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F 656	Continued From page 7	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		4/6/21

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F 656	Continued From page 8 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of four residents in the survey sample, Resident #1. The facility staff failed to administer aspirin 81 mg (milligrams) per the comprehensive care plan to Resident #1 on 2/12/21. The findings include: Resident #1 was admitted to the facility on 3/3/20. Resident #1's diagnoses included but were not limited to stroke, history of heart attack and chronic kidney disease. Resident #1's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/31/21, coded the resident as being cognitively intact. Review of Resident #1's clinical record revealed a physician's order dated 8/15/20 for aspirin (1) 81 mg (milligram)- one tablet by mouth one time a day for pvd (peripheral vascular disease) (2). Resident #1's comprehensive care plan dated 2//4/21 documented, "(Resident #1) has Peripheral Vascular Disease (PVD). Give medications for improved blood flow or anticoagulants (blood thinning medication) as ordered..."	F 656	1. Resident #1 care plan is being followed. 2. All residents have the potential to be affected. Quality review of residents' Care Plan of the past 7 days to be completed by April 2, 2021 to verify Care plans are implemented as written. 3. Licensed nurses to be re-educated by DON/Designee by April 2, 2021 on implementing of residents' care plans as written. 4. DON/Designee will conduct quality review of 10% of residents' care plan to ensure implementation as written weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6, 2021.	

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F 656	Continued From page 9	F 656		

Review of Resident #1's February 2021 MAR (medication administration record) revealed the above physician's order for aspirin 81 mg and on 2/12/21, the nurse documented the code "9=Other/See Nurse Notes." A nurse's note dated 2/12/21 documented, "not available."

On 3/10/21 at 11:22 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to show everybody how to provide care for the residents and what their needs may be. RN #1 stated residents' care plans are always available for reference for nurses to ensure they are implementing them.

On 3/10/21 at 12:09 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the above nurse's note on 2/12/21. LPN #1 stated most over the counter bulk medications are available in the facility supply room and if the medication is not available then someone can go to Walmart and purchase the medication. LPN #1 was made aware of her documentation regarding Resident #1's aspirin on 2/12/21. LPN #1 stated she really did not remember the situation but there was one point when the nurses did not have aspirin 81 mg and that was a bulk house stock medication so staff would have to wait for that order to arrive or someone would have to go to the store and purchase the medication. LPN #1 stated she thought she told someone that there was not aspirin 81 mg available but she did not remember who she told.

Review of the bulk supply house stock medication list revealed the facility was responsible for ordering aspirin 81 mg.

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F 656	Continued From page 10 On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern. The facility policy titled, "Plans of Care" documented, "Develop and Implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team..." No further information was presented prior to exit. References: (1) "Aspirin therapy is very helpful for people with CAD (coronary artery disease) or a history of stroke." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000092.htm (2) "Your peripheral arteries and veins carry blood to and from your arm and leg muscles and the organs in and below your stomach area. PVD may also affect the arteries leading to your head (see Carotid Artery Disease). When PVD affects only the arteries and not the veins, it is called peripheral arterial disease (PAD). The main forms that PVD may take include blood clots (for example, deep vein thrombosis or DVT), swelling (inflammation), or narrowing and blockage of the blood vessels." This information was obtained from the website: https://www.texasheart.org/heart-health/heart-information-center/topics/peripheral-vascular-disease/	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		4/6/21

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F 677	Continued From page 11 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide ADL (activities of daily living) care for one of four sampled residents, Resident #4, who was assessed and coded as dependent on staff for care. Resident #4, who was assessed and coded as being dependent on staff for personal hygiene and bed mobility, was not provided assistance by facility staff to get out of bed from 4/28/20 through 5/8/20 and from 5/10/20 through 5/14/20, and the facility staff failed to provide bathing for Resident #4 from 4/28/20 through 5/7/20. The findings include: Resident #4 was admitted to the facility on 4/28/20. Resident #4's diagnoses included but were not limited to heart failure, urinary tract infection and severe chronic kidney disease. Resident #4's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/2/20, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #4 as requiring total dependence of two or more staff with bed mobility, requiring extensive assistance of one staff with dressing and eating and as requiring total dependence of one staff	F 677	1. Resident #4 is no longer a residents of the facility. 2. All residents have the potential to be affected. Quality review of residents' ADLs of the past 7 days to be completed by April 2, 2021 to ensure ADL care provided for residents. 3. Facility nursing staff to be re-educated by DON/ Designee by April 2, 2021 on providing residents with ADL care to include personal hygiene and bed mobility. ADL Care will be monitored during clinical meeting to ensure completed on residents. 4. DON/Designee will conduct a quality review of 10% of residents' ADL care to ensure compliance weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6, 2021	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12	F 677		

with personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands [excludes baths and showers]). Section G further coded transfers and bathing as not having occurred during the seven day look back period.

Resident #4's baseline care plan with an admission date of 4/28/20 documented "Self-Care Deficit-ADL Function Rehab Potential..." Resident #4 expired on 5/20/20.

Review of Resident #4's clinical record failed to reveal physical therapy and occupational therapy notes.

Review of nurses' notes and CNA (certified nursing assistant) ADL documentation from 4/28/20 through 5/20/20 failed to reveal evidence that Resident #4 was assisted out of bed except for a nurse's note dated 5/9/20 that documented Resident #4 was up in the wheel chair and ADL transfer documentation that documented Resident #4 was transferred on 5/15/20 and 5/16/20.

Nurses' notes and CNA ADL documentation from 4/28/20 through 5/7/20 failed to reveal evidence that Resident #4 was provided bathing, including a partial bed bath, complete bed bath or shower. Further review of Resident #4's clinical record failed to reveal documentation that the resident refused to get out of bed or was not physically capable of getting out of bed until the resident's condition deteriorated on 5/17/20. The clinical record also failed to reveal Resident #4 refused bathing or was not physically capable of being bathed from 4/28/20 through 5/7/20.

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F 677	Continued From page 13 A CNA who routinely cared for Resident #4 was not available for interview during the survey. On 3/11/21 at 11:46 a.m., an interview was conducted with CNA #2, regarding the process for bathing residents and getting residents out of bed. CNA #2 stated residents are provided a partial bed bath or complete bed bath every day and provided a shower twice a week. CNA #2 stated she asks residents if they want to get out of bed and gets them out of bed based on their preferences. CNA #2 stated if residents can't speak for themselves and are physically able to get out of bed then she gets them out of bed. CNA #2 stated it is better for residents to eat while sitting in a chair. CNA #2 stated she documents in the ADL records when she bathes residents and gets residents out of bed. On 3/11/21 at 12:11 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concerns. No further information was presented prior to exit.	F 677		
F 684 SS=D	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		4/6/21

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F 684	Continued From page 14 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a house stock medication was available for administration for one of four residents in the survey sample, Resident #1. The facility staff failed to administer aspirin 81 mg (milligrams) per physician's order to Resident #1 on 2/12/21. The findings include: Resident #1 was admitted to the facility on 3/3/20. Resident #1's diagnoses included but were not limited to stroke, history of heart attack and chronic kidney disease. Resident #1's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/31/21, coded the resident as being cognitively intact. Review of Resident #1's clinical record revealed a physician's order dated 8/15/20 for aspirin (1) 81 mg- one tablet by mouth one time a day for pvd (peripheral vascular disease) (2). Resident #1's comprehensive care plan dated 2//4/21 documented, "(Resident #1) has Peripheral Vascular Disease (PVD). Give medications for improved blood flow or anticoagulants (blood thinning medication) as ordered..." Review of Resident #1's February 2021 MAR (medication administration record) revealed the above physician's order for aspirin 81 mg and on	F 684	1. Resident #1 MD/NP was notified of aspirin 81mg not administered as ordered. No new orders given. 2. All residents have the potential to be affected. Quality review of house stock medications of the past 7 days to be completed by April 2, 2021 to ensure medications are available per MD orders. 3. Licensed nurses/Central Supply Clerk to be re-educated by DON/ Designee by April 2, 2021 on ensuring house stock medications are available per MD orders. House stock medications will be monitored during clinical meeting to ensure administered per MD orders. 4. DON/Designee will conduct a quality review of 10% of residents' MARs to ensure house stock medications are available per MD orders weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6, 2021	

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F 684	Continued From page 15	F 684		

2/12/21, the nurse documented the code "9=Other/See Nurse Notes." A nurse's note dated 2/12/21 documented, "not available."

On 3/10/21 at 12:09 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the above nurse's note on 2/12/21. LPN #1 stated most over the counter bulk medications are available in the facility supply room and if the medication is not available then someone can go to Walmart and purchase the medication. LPN #1 was made aware of her documentation regarding Resident #1's aspirin on 2/12/21. LPN #1 stated she really did not remember the situation but there was one point when the nurses did not have aspirin 81 mg and that was a bulk house stock medication so staff would have to wait for that order to arrive or someone would have to go to the store and purchase the medication. LPN #1 stated she thought she told someone that there was not aspirin 81 mg available but she did not remember who she told.

Review of the bulk supply house stock medication list revealed the facility was responsible for ordering aspirin 81 mg.

On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern.

The facility policy titled, "Medication-Oral Administration of" failed to document information regarding medication unavailability from the bulk house stock supply.

No further information was presented prior to exit.

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F 684	Continued From page 16 References: (1) "Aspirin therapy is very helpful for people with CAD (coronary artery disease) or a history of stroke." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000092.htm (2) "Your peripheral arteries and veins carry blood to and from your arm and leg muscles and the organs in and below your stomach area. PVD may also affect the arteries leading to your head (see Carotid Artery Disease). When PVD affects only the arteries and not the veins, it is called peripheral arterial disease (PAD). The main forms that PVD may take include blood clots (for example, deep vein thrombosis or DVT), swelling (inflammation), or narrowing and blockage of the blood vessels." This information was obtained from the website: https://www.texasheart.org/heart-health/heart-information-center/topics/peripheral-vascular-disease/	F 684		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		4/6/21

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F 727	Continued From page 17 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to use the services of a RN (registered nurse) for at least 8 consecutive hours a day, seven days a week. The facility staff failed to ensure RN coverage on 1/10/21. The findings include: Review of January 2021 nurse staffing schedules failed to reveal any RN coverage for 1/10/21. On 3/10/21 at 9:33 a.m., an interview was conducted with ASM (administrative staff member) #2 (the interim director of nursing). ASM #2 stated the former staffing coordinator was no longer employed at the facility and the new staffing coordinator was still in training. In regards to RN coverage, ASM #2 stated the facility must staff a RN for 8 hours, every 24 hours and the only time there is difficulty doing this is during the weekends because there are RNs in management and the MDS (minimum data set) office during the week. ASM #2 was asked what she does if a RN is not scheduled. ASM #2 stated she gets on the phone and asks RNs to work. On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern.	F 727	1. Facility staffs RN coverage for at least 8 consecutive hours a day, seven days a week. 2. All residents have the potential to be affected. 3. Facility scheduler and DON will be re-educated on staffing a RN for at least 8 consecutive hours a day, seven days a week. Nursing schedules will be monitored during facility staffing meetings to ensure compliance. 4. DON/Designee will conduct a review of the nursing schedule to ensure compliance on staffing a RN for at least 8 consecutive hours a day, seven days a week, weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6, 2021	

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F 727	Continued From page 18 On 3/11/21 at 11:31 a.m., ASM #1 confirmed the facility did not have a policy regarding RN coverage. No further information was presented prior to exit.	F 727		
F 755 SS=D	COMPLAINT DEFICIENCY 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 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	F 755		4/6/21

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F 755	Continued From page 19 §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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide pharmaceutical services to meet the needs of one of four sampled residents, (Resident #2). The facility staff failed to ensure Resident #2's physician prescribed, Lyrica (1) - 50 mg (milligram)- one capsule by mouth three times a day for neuropathic pain, was available for administration to the resident three time on 1/2/21, and two time on 2/12/21. The findings include: Resident #2 was admitted to the facility on 3/27/20. Resident #2's diagnoses included but were not limited to paralysis, diabetes and heart failure. Resident #2's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/4/20, coded the resident as being cognitively intact. Review of Resident #2's clinical record revealed a physician's order dated 8/14/20 for Lyrica (1) - 50 mg- one capsule by mouth three times a day for neuropathic pain. Resident #2's comprehensive care plan dated 4/9/20 did not document specific information regarding Lyrica administration. Review of Resident #2's January 2021 and	F 755	1. Resident #2 2 MD/NP was notified of Lyrica not administered as ordered. No new orders given. 2. All residents have the potential to be affected. Quality review of residents' MARs of the past 7 days to be completed by April 2, 2021 to verify medications are available from pharmacy for administration per MD orders. 3. Licensed nurses to be re-educated by DON/ Designee by April 2, 2021 on ensuring medications are available from pharmacy for administering medications per MD/NP orders. MARs will be monitored during clinical meeting to ensure medications are available from pharmacy for administration per the MD order and medications re-ordered from the pharmacy timely. 4. DON/Designee will conduct a quality of 10% of residents' MARs to ensure medication are available from pharmacy and administered per the MD order and medications are re-ordered from the pharmacy timely, weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of April 6,	

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F 755	Continued From page 20	F 755	2021	

February 2021 MARs (medication administration records) revealed the above physician's order for Lyrica and revealed on 1/2/21 at 6:00 a.m., 2:00 p.m. and 10:00 p.m., and on 2/12/21 at 6:00 a.m. and 2:00 p.m., the nurses documented the code "9=Other/See Nurse Notes."

Review of Resident #2's nurses notes revealed the following:
-A nurse's note dated 1/2/21 at 5:31 a.m. documented, "Waiting availability from pharmacy."
-A nurse's note dated 1/2/21 at 1:40 p.m. documented, "awaiting arrival from pharmacy."
-A nurse's note dated 1/2/21 at 9:25 p.m. documented, "awaiting from pharmacy."
-A nurse's note dated 2/12/21 at 5:49 a.m. documented, "awaiting delivery."
-A nurse's note dated 2/12/21 at 1:37 p.m. documented, "on order from pharmacy."

On 3/10/21 at approximately 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who documented the above note on 2/12/21 at 5:49 a.m. LPN #2 stated medications can be refilled through the facility computer system or by calling the pharmacy. LPN #2 stated if a medication is not available for administration, she can check the STAT (immediate) box (a box containing various medications) and if the medication is not in the STAT box then nurses should call the pharmacy and contact the physician or nurse practitioner. LPN #2 was made aware of her note regarding Resident #2's Lyrica on 2/12/21. LPN #2 stated Lyrica was not in the STAT box. LPN #2 stated a prescription would have had to been involved and she guessed that facility staff were probably waiting on the pharmacy to refill the medication,

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F 755	Continued From page 21	F 755		

but she was not really sure.

On 3/10/21 at 11:59 a.m., an interview was conducted with RN (registered nurse) #2, the nurse who documented the above notes on 1/2/21 at 5:31 a.m. and 1/2/21 at 9:25 p.m. RN #2 stated she reorders medications when there is a couple days of supply left. RN #2 stated if a medication is not available for administration, she checks the STAT box. When asked what she does if the medication is not in the STAT box, RN #2 stated, "Well if not in the STAT box then I have nowhere else to get it from so I can't get it." RN #2 stated she can make sure the medication has been ordered and can call the pharmacy after hours phone line to see when the medication is going to arrive. RN #2 could not recall if she called the pharmacy regarding Resident #2's Lyrica on 1/2/21.

On 3/10/21 at 12:09 p.m., an interview was conducted with LPN #1, the nurse who documented the above notes on 1/2/21 at 1:40 p.m. and 2/12/21 at 1:37 p.m. LPN #1 stated the pharmacy is slower with medication delivery on the weekends so on Tuesdays, she looks to see how much supply of medications is left and reorders enough medications for administration through the weekend. LPN #1 stated if a medication is not available, then nurses can pull some medications from a facility STAT box but the STAT box does not contain all medications. LPN #1 was made aware of her notes regarding Resident #2's Lyrica on 1/2/21 and 2/12/21. LPN #1 stated she did not recall specific details regarding those dates but if she documents a note like those, then the nurses must have sent the prescription for the medication and were waiting for the pharmacy to deliver.

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F 755	Continued From page 22	F 755		

Review of the facility/pharmacy STAT box list revealed Lyrica was not in the STAT box.

On 3/10/21 at 4:15 p.m., ASM #1 (the interim executive director) and ASM #3 (the regional vice president of operations) were made aware of the above concern.

The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "Procedure: 1. Upon discovery that Facility has inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0, as applicable.
2. If a medication shortage is discovered during normal Pharmacy hours:
2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery.
2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply (STAT box) to administer the dose.
2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery.
3. If a medication shortage is discovered after normal Pharmacy hours:
3.1 A licensed Facility nurse should obtain the

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F 755	Continued From page 23 ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action..." No further information was presented prior to exit. Reference: (1) Lyrica is used to treat pain from damaged nerves. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605045.html	F 755		