STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

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

An unannounced Emergency Preparedness survey was conducted 07/13/2021 through 07/15/2021. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.

E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		8/23/21

§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/06/2021

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

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	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 015	Continued From page 1	E 015		

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed to obtain contractual agreements to ensure provisions for food, water, sewage, and disposable services during an emergency.

The findings include:

On 07/15/2021 at approximately 3:30 P.M., this surveyor and the administrator reviewed the facility's emergency plan. When the administrator was asked about the provision of subsistence (food, water, sewage, and disposal services) for Residents during an emergency, the Administrator presented the following:

The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

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	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

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E 015	Continued From page 2 1) For water and waste disposal: The Administrator presented 3 documents. An excerpt of Document #1 included the following: "In the event of disruption of the water supply, the following steps should be taken: The Dining Services Department will maintain a standard inventory supply of bottled water within the Center. Additional water needs will be ordered and supplied through pre-established vendor arrangements. Contact the following vendor(s) for emergency water supplies. Emergency Water Supply Vendor: [vendor company name]. Contact Number: [vendor phone number]." Document #2 entitled, "Interrupted Domestic Water Supply." documented the following: "In the event of interrupted domestic water service, notify the administrator and the Director of Maintenance. The local water utility provider and local office of emergency services should be contacted immediately. Local water utility provider: [company name and number]." An excerpt on Document #3 under the header, "Back-Up Portable Toilets" documented, "In the event that the facility sewage system fails and it affects facility toilet services in the facility will call [company name] to rent portable toilets. [Company name] has same-day delivery and has an emergency service with operating services 24/7. The administrator or designee will call number to order the portable toilets." Under the header, "Waste Disposal" it was documented, "In the event of impending inclement weather, the administrator or designee will contact contracted waste company [company name and number] to request an extra pick up and/or an extra waste	E 015	E015 1- The Administrator obtained a contractual agreement with the vendors that provide provisions for food, water, sewage and disposable services during an emergency. A copy of the contracts are available for view in the Emergency Preparedness plan binder. 2- The Administrator will review the Emergency Preparedness plan to ensure that contracts are in place and up to date. 3- The Administrator has referenced the Emergency Preparedness policies and procedures to include the need to have contractual agreements in place and up to date. 4- The Administrator will review the Emergency Preparedness plan on an annual basis to ensure that the vendor contracts that provide provisions for food, water, sewage and disposable services are in place and up to date. Results of the audit will be presented to the QAPI committee for review and recommendations. 5- Completion date 8/23/21.	

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	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 015	Continued From page 3 container to be delivered to be used for extra waste capacity until the contracted waste vendor can resume normal operations." There were no contractual agreements with these companies presented by the administrator. 2) Pertaining to Food: The administrator presented 4 documents. Document #1 was entitled, "Dietary Department Emergency Preparedness Chart." The chart contained four columns entitled "Item", "Vendor Name", "Contact Person", and "Phone Number." The second chart on the page was entitled, "Emergency Power" with the subtitle, "The following major kitchen equipment is on the emergency generator." The chart had three columns entitled, "Item, "Yes", and "No." Document #2 was entitled, "[Company Name] Preparedness & Response Framework" with the following sub headers: "Crisis Management Structure & Teams", "Emergency Preparedness and Crisis Management Plans", Technology and Communication", and "Critical Infrastructure/Key Resource". There was no contractual agreement with this company presented by the administrator. When asked about a contractual agreements, the administrator stated that document number 23 and four was a clause out of a contract but a contract was not presented. On 07152021 at 4:35 PM, the administrator was notified of concerns for lack of contractual agreements for food, water, sewage, and disposal. By the end of survey, the administrator submitted no further documentation or information.	E 015		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		8/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 041	Continued From page 4	E 041		

§482.15(e) Condition for Participation:
(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)
(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 041	Continued From page 5 LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014.	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 041	Continued From page 6 (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to obtain contractual agreements to ensure the generator will remain operational during an emergency. The findings include: On 07/15/2021 at approximately 3:30 P.M., this surveyor and the administrator reviewed the facility's emergency plan. When the administrator was asked about the emergency plan for how to keep the generator operational during an emergency, the Administrator presented the following 2 documents: Document #1 entitled, "Generator Diesel Tank Refueling" contained the following excerpt: "The facility has an on-site diesel fuel tank for the emergency power generator. This fuel tank is verified to be in accordance with NFPA regulations. The Maintenance Director closely monitors facility diesel fuel tank levels. In the event of an emergency that requires emergency	E 041	E041 1- The Administrator obtained a contractual agreement with the generator diesel fuel vendor that provides services during an emergency. A copy of the contract is available for view in the Emergency Preparedness plan binder. 2- The Administrator will review the Emergency Preparedness plan to ensure that contracts are in place and up to date. 3- The Administrator has referenced the Emergency Preparedness policies and procedures to include the need to have contractual agreements in place and up to date. 4- The Administrator will review the Emergency Preparedness plan on an annual basis to ensure that the vendor contracts that provide services to ensure that the generator is operational in the event of an emergency is in place and up to date. Results of the audit will be presented to the QAPI committee for review and recommendations.	

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	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

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E 041	Continued From page 7 generator power, the Maintenance Director will contact the diesel fuel provider to notify of the facility status." Document #2 entitled "Letter of Intent" documented the following: "In the event of an emergency power generator use, [company name] is available to assist with diesel tank refueling. Please call [number] when services are needed." The document was signed by the vendor sales representative and dated "1-19-21". The was no contractual agreement with the fuel vendor presented by the administrator. On 07152021 at 4:35 PM, the administrator was notified of concerns for lack of contractual agreements for refueling their generator in the event of an emergency. By the end of survey, the administrator submitted no further documentation or information.	E 041	5- Completion date 8/23/21.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated standard survey was conducted 7/13/2021 through 7/15/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00050645 - substantiated without deficiency) was investigated during the survey. The census in this 60 licensed bed facility was 53 at the time of the survey. The survey sample consisted of 21 Resident reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		8/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 8	F 658		

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to provide services in accordance with professional standards of practice for 2 Residents (Resident #2 and Resident #8), in a survey sample of 21 Residents.

1. For Resident #2 the facility staff failed to document the administration of Byetta insulin as ordered by the physician. The facility staff documented the administration of Bydureon insulin, despite this order being discontinued.

2. For Resident #8 the facility failed to give Oxycodone 20 mg every four hours as ordered by the physician, and failed to document why medications were held.

The findings included:

1. For Resident #2 the facility staff failed to document the administration of Byetta insulin as ordered by the physician. The facility staff documented the administration of Bydureon insulin, despite this order being discontinued.

Resident #2 was admitted to the facility 10/15/20. Diagnosis for Resident #2, included but were not limited to: hemiplegia affecting left non-dominant side, sepsis, type 2 diabetes with diabetic polyneuropathy, and chronic kidney disease stage 3b.

F658
1-The Licensed nurses involved in the documentation error involving Resident #2 were educated on proper medication administration documentation. Resident #2 has been assessed by the PA and is receiving medication to manage his Diabetes. A clarification order was received for Resident #8, which specifies to wake the resident for the administration of Oxycodone if he is sleeping, per the resident□s request.
2- All residents receiving medications are at risk for deficient practice related to the need for proper administration and documentation of medication. The DON or designee will complete an audit of all residents receiving Insulin and routine pain medication to ensure that the residents are receiving the correct medication as ordered and that if any medications are held that there is evidence documented why a medication was held.
3-The Staff Development Coordinator will educate licensed Nurses on the Rights of Medication Administration and proper documentation of reasons for medication omission or medications being held.
4-The Unit Manager or designee will complete audits of residents receiving Insulin and routine pain medication to ensure that the residents are receiving the

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	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

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F 658	Continued From page 9	F 658		

Resident #2's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/1/21, was coded as a quarterly assessment. Resident #2 was coded on this assessment as having had a BIMS (brief interview for mental status) score of 15, indicating no cognitive impairments. He was also coded as having required extensive assistance of facility staff for personal hygiene, dressing, bed mobility and toileting.

On 7/14/21, a review of conducted of Resident #2's electronic health record. This review revealed the following:
1. On 5/20/21, Resident #2 was seen by the physician. The physician progress note following this visit read, "Return to Trulicity. HE CANNOT BE ON BYDUREON DUE TO CHRONIC KIDNEY DISEASE!" This entry was capitalized and bolded.
2. On 5/27/21, there was a physician order that read, "1. D/c [discontinue] Bydureon. 2. Restart Trulicity as previously ordered".
3. Review of the MAR (Medication Administration Record) revealed that facility staff signed off on giving the Bydureon on 6/5/21, 6/12/21 and 6/19/21, despite this medication being ordered to stop on 5/27/21.
4. The MAR revealed that the order for Byetta (also known as Trulicity), was not entered onto the MAR for Resident #2 until 7/3/21, but was also discontinued on the MAR the same day.

Review of the blood sugar results for Resident #2 revealed that his blood sugar readings vary significantly: May readings varied from 143-322. June readings were from 99-277. July blood sugar readings were 121-300. Staff were

correct medication as ordered and that if any medications are held that there is evidence documented why a medication was held. The audits will be completed 3x week x 4 weeks, weekly x2, and then monthly x1. Results of the audits will be presented to the QAPI Committee for review and recommendation.
5-Completion date 8/23/21.

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 658	Continued From page 10	F 658		

checking his blood sugars four times daily.

During the morning of 7/15/21, the facility Director of Nursing (DON) (Employee B), Nurse Consultant (Employee E), Unit Manager (Employee F), and Registered Nurse/Infection Preventionist (Employee K) were notified that the insulin order change on 5/27/21, for Resident #2 did not appear to have been carried out. They were also made aware that it appeared Resident #2 had continued to receive the insulin that had been ordered to stop due to his chronic kidney disease.

The facility's clinical management staff, Employees B, E, F and K looked into the aforementioned details. On 7/15/21 at 12:54 PM, they shared the following findings:
Employee F stated, "I called the doctor right away to let them know, [Nurse Practitioner's name redacted] said she is going to see him tomorrow, she is concerned about his kidneys so she isn't going to start the Trulicity, she reviewed his blood sugars and told us to continue to monitor and not start the trulicity right now".

Employee K stated, "He has been getting the Byreta/Trulicty and not the Bydrudron. But there is still an error. At the time the changeover was happening [change in facility ownership/change in computer system] he was changed from Bydudron to Trulicity, so our system was down for a few days. We called the pharmacist and they said they sent out Trulicity on 5/20/21, 6/11/21 and 7/2/21, when the system switched over the trulicity didn't come up, the names didn't change, it didn't get transposed correctly into [electronic health record program name redacted], the Byretta is on the MAR but that they are not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 11	F 658		

actually giving that one. The error I'm finding, they are documenting the wrong insulin, he is getting the correct insulin currently and he was getting the correct insulin. The Bydureon was last delivered on 5/5/21, and the Trulicity was filled May 20". Employees B, E, F and K, all concurred that facility staff were signing off on a medication that they were not giving.

On 07/15/21 at 03:36 PM, the DON was asked what processes are in place to when administering medications (meds) to prevent such errors from occurring. She stated, "You sign off on the meds you are giving, you administer it and then sign off on it". The other clinical management staff were in the room and collectively they all stated, "When passing meds what you are supposed to do is compare the ordered drug to actual drug bottle/package, check the label, you are supposed to double check and make sure, right med, right dose, right time". When asked what Professional Nursing Standards of Practice are followed, the Nurse Consultant stated, "Lippincott and Mosby".

Review of the facility policy titled, "General Dose Preparation and Medication Administration" read, "4. Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..... 4.1.2 Confirm that the MAR reflects the most recent medication order...."

"Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 12	F 658		

or harm clients."
Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, and General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient. Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system).
2. Right medication. Check the medication label. Check the order.
3. Right dose. Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route. Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route.
5. Right time. Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given.
6. Right documentation. Document administration AFTER giving the ordered medication.
Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 13 7. Right reason. Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. 8. Right response. Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. The facility Administrator and Director of Nursing (DON) were informed of the failure to document the Administration of insulin ordered for Resident #2 as well as the documentation of administration of the insulin that had been discontinued on 7/15/21. No further information was provided.	F 658		

2. For Resident #8, the facility staff failed to ensure medications were administered as ordered by the physician.

Resident # 8, a 68 yr. old male admitted to the facility on 3/11/20 with diagnoses of but not limited to esophageal cancer, anxiety,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 14	F 658		

depression, COPD, malignant neoplasm of supraglottis, cirrhosis of liver, chronic pain related to cancer, and calculus of gallbladder and bile duct (gall stones still present in gall bladder and bile duct) with acute and chronic cholecystitis.

The most recent MDS was a Quarterly with an ARD of 4/14/21. Resident #8 was coded as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident #8 is coded as being independent with most ADL's with the exception of eating as he has a peg tube that is being used to supplement his diet, as he has issues maintaining an ideal body weight due to the diagnosis of cancer. He can ambulate independently but uses a wheel chair for mobility on unit due to fatigue.

On 7/14/21 during clinical record review revealed that Resident #8's physicians order read: Oxycodone 20 mg. Immediate Release give 1 tablet every four hours. [Per MAR the Scheduled times are: 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, 10:00 PM]

A review of the MAR (medication administration record revealed the resident missed 25 doses of scheduled pain medication between 5/24/21 and 7/14/21 they - are as follows:

05/24/21 - 2:00 AM dose - Signed off in MAR as #7 - sleeping- No progress note in chart.
05/29/21 - 10:00 PM dose - not signed off on MAR, signed out in Narc book no progress note
05/31/21 - 2:00 AM dose - not signed off on MAR, and no progress note
06/07/21 - 2:00 AM dose - signed off in MAR as not given coded as #7 Sleeping
06/13/21 - 2:00 AM dose - MAR signed off not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 15	F 658		

given coded as #7 - Sleeping
06/14/21- 2:00 AM dose - MAR signed off not given coded as #7 Sleeping
06/18/21 - 2:00 AM dose - MAR signed off not given coded as #7 Sleeping
06/19/21 - 2:00 AM dose - MAR signed off not given coded as #7 Sleeping
06/20/21 - 6:00 PM dose - MAR signed off as not given coded as #5 see nurses note. Progress notes state " 6/20/2021 20:07 Orders - Administration Note Text: oxycodone HCl Tablet 20 MG Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via PEG per pt. preference. Resident outside"
06/22/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
06/27/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
06/28/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/01/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/02/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/03/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/04/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/06/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/07/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping
07/09/21- 6:00 PM dose - MAR signed off not given coded as #9 - Other see progress notes Progress notes. No Progress notes entered for time to explain not giving medication
07/09/21- 10:00 PM dose - MAR not signed off space blank. Narcotics book does not reflect medication being given. No progress note to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 16	F 658		

explain why med was held.
[For 7/9/21 - The medication Card on the Narcotics sign out sheet shows the last oxycodone being used for the 2:00 PM dose on 7/9/21 a new card was not started until 7/10/21 at 6:00 PM]
07/10/21- 2:00 AM dose - MAR was left blank for this dose nothing was signed out in the Narcotics book and the following notes were found in the progress note.
"7/10/2021 02:00 Orders - Administration Note Incorrect Documentation - Note Text: Oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain PSR 4-10; may give per PEG per pt. preference."
[Nurses name redacted]
"7/10/2021 02:00 Orders - Administration Note Text: Oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain PSR 4-10; may give per PEG per pt. preference
07/10/21- 6:00 AM dose - MAR was left blank for this dose nothing was signed out in the Narcotics book and the following notes were found in the progress note.
7/10/21 10:00 AM dose- MAR was signed off as not given and coded as #9 other see progress notes The progress notes read :
"7/10/2021 09:36 Orders - Administration Note Text: oxycodone HCl Tablet 20 MG "Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via PEG per pt. preference
"Resident not given scheduled oxycodone 20 mg because it is not in the facility or on the med cart. Pharmacy has been contacted regarding this issue as well."

07/10/21- 2:00 PM dose - MAR signed as not given coded as #9 - other see progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 17	F 658		

Progress notes read as follows:

"7/10/2021 14:42 Orders - Administration Note Text: oxycodone HCl Tablet 20 MG Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via PEG per pt. preference Medication not in facility. Pharmacy contacted and aware that this is a scheduled medication for this resident and that we will need it delivered ASAP. Unit manager also made aware, RN on duty in facility today also made aware of same."

7/10/2021 3:33 PM Orders - Administration Note Text: oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain PSR 4-10; may give per PEG per pt. preference PRN Administration was: Effective Follow-up Pain Scale was: 5

07/11/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping. No progress note found for this time.

07/14/21- 2:00 AM dose - MAR signed off not given coded as #7 - Sleeping No progress note found for this time.

On 7/14/21 at 1:43 PM an interview was conducted with the DON who stated it was her expectation that if an order was written then the nurse carry out the order as it is written. When asked if a medication was ordered to be given every 4 hours how many times a day and what times should it be given she responded well usually the pharmacy would print out the times on the MAR unless the doctor specified times. When asked if it was usual practice for nurses to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 18	F 658		

hold medicine because a resident is asleep and she said no.

On 7/14/21 at 1:55 PM an interview was conducted with the unit manager who was asked what the nurses were expected to do if they held a medication, and she stated that the nurses were expected to call the provider and the RP and document why a medication is being held or not given.
She was asked to explain the process of ordering a refill of narcotics and she stated that it depended if it was scheduled or PRN (as needed). When she was told a scheduled narcotic she stated that usually the nurse would reorder the medication when there were a few doses left to give the pharmacy time to get it to the facility. She also stated that "If a hard script is needed by the pharmacy we expect the nurses to call the provider to get it sent over to the pharmacy.' She stated this is usually not a problem because the PA (physician's assistant) is usually in the building every day except Thursday. The unit manger stated that it was her expectation that if a medication was not available to give a Resident the nurses should check the stat box, if its not in the stat box, notify the pharmacy, phone the physician to see if he wanted to change the order to something similar that we have in the stat box , notify the Resident or RP and document all of it in the chart.
A review of the Stat Box Contents Sheet revealed that the Oxycodone 20 mg was not available in the stat box.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 658	Continued From page 19 such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. On 7/15/21 during the end of day conference the Administrator was made aware of the concerns and no new information was provided.	F 658		
F 755 SS=E	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.	F 755		8/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 755	Continued From page 20 §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 §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 observation, interview, facility documentation and clinical record review, the facility staff failed to provide routine medications to 4 Residents (#'s 8, 36, 51, and 26) in a Survey sample of 21 Residents. The Findings included: 1. For Resident #8 the facility staff failed to ensure he had an adequate supply of routinely scheduled oxycodone (narcotic pain medication). Resident # 8, a 68 yr. old male admitted to the facility on 3/11/20 with diagnoses of but not	F 755	F755 1-Resident #36, 51 and 26 all have medications available for administration. Resident #8 has an adequate supply of Oxycodone and is receiving the medication as prescribed. 2- All residents receiving medications are at risk for deficient practice related to the need for availability of the medications and proper administration and documentation of medication. The DON or designee will review the medication administration records for current residents to ensure all medications are available for administration. The Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 755	Continued From page 21	F 755		

limited to esophageal cancer, anxiety, depression, COPD, malignant neoplasm of supraglottis, cirrhosis of liver, chronic pain related to cancer, and calculus of gallbladder and bile duct (gall stones still present in gall bladder and bile duct) with acute and chronic cholecystitis.

The most recent MDS was a Quarterly with an ARD of 4/14/21. Resident #8 was coded as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident #8 is coded as being independent with most ADL's with the exception of eating as he has a peg tube that is being used to supplement his diet, as he has issues maintaining an ideal body weight due to the diagnosis of cancer. He can ambulate independently but uses a wheel chair for mobility on unit due to fatigue.

On 7/14/21 during clinical record review revealed that Resident #8's physicians order read: Oxycodone 20 mg. Immediate Release give 1 tablet every four hours. [Per MAR the scheduled times are: 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, 10:00 PM]

05/29/21 - 10:00 PM dose - not signed off on MAR, signed out in Narc book no progress note
05/31/21 - 2:00 AM dose - not signed off on MAR, and no progress note

06/20/21 - 6:00 PM dose - MAR signed off as not given coded as #5 see nurses note. Progress notes stated 6/20/2021 8:07 PM Orders - Administration Note Text: oxycodone HCl Tablet 20 MG Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via

Manager or designee completed an audit of each Medication cart compared to the Medication Administration Record to ensure that the medications are available for administration.
3- The Staff Development Coordinator will educate Nurses on the correct documentation and pharmacy guidelines to include re-ordering medications, following physician orders for medication administration, STAT box contents and utilization of the STAT box and utilizing the House stock availability of medications.
4-The Unit manager or designee will review the Medication administration records and shift report on a weekly basis for any indication of omissions or medications not available. The Unit Manager or designee will complete a random audit of medications on the med cart compared to the Medication Administration record to ensure that the medications are available for administration. The audits will be completed 3x week x 4 weeks, weekly x 2, and then monthly x1. Results of the audits will be presented to the QAPI Committee for review and recommendation.
5-Completion date 8/23/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 755	Continued From page 22	F 755		

PEG per pt. preference. "Resident outside"

07/09/21- 6:00 PM dose - MAR signed off not given coded as #9 - Other see progress notes Progress notes.
No Progress notes entered for time to explain not giving medication

07/09/21- 10:00 PM dose - MAR not signed off space blank. Narcotics book does not reflect medication being given. No progress note to explain why med was held.

[For 7/9/21 - The medication Card on the Narcotics sign out sheet shows the last oxycodone being used for the 2:00 PM dose on 7/9/21 a new card was not started until 7/10/21 at 6:00 PM]

07/10/21- 2:00 AM dose - MAR was left blank nothing was signed out in the Narcotics book and the following notes were found in the progress note.

"7/10/2021 2:00 AM Orders - Administration Note Incorrect Documentation - Note Text: Oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain PSR 4-10; may give per PEG per pt. preference."
[The nurse gave Resident #8 his PRN dose of 5 mg instead of the routine 20 mg ordered for 2 AM]

07/10/21- 6:00 AM dose - MAR was left blank for this dose nothing was signed out in the Narcotics book and the following notes were found in the progress note.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 755	Continued From page 23	F 755		

7/10/21 10:00 AM dose- MAR was signed off as not given and coded as #9 other see progress notes The progress notes read :

"7/10/2021 09:36 Orders - Administration Note Text: oxycodone HCl Tablet 20 MG "Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via PEG per pt. preference "Resident not given scheduled oxycodone 20 mg because it is not in the facility or on the med cart. Pharmacy has been contacted regarding this issue as well."

07/10/21- 2:00 PM dose - MAR signed as not given coded as #9 - other see progress notes. Progress notes read as follows:

"7/10/2021 2:42 PM Orders - Administration Note Text: oxycodone HCl Tablet 20 MG Give 1 tablet by mouth every 4 hours for cancer pain hold for somnolence; may give via PEG per pt. preference Medication not in facility. Pharmacy contacted and aware that this is a scheduled medication for this resident and that we will need it delivered ASAP. Unit manager also made aware, RN on duty in facility today also made aware of same."

7/10/2021 3:33 PM Orders - Administration Note Text: oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain PSR 4-10; may give per PEG per pt. preference PRN Administration was: Effective Follow-up Pain Scale was: 5 [PRN dose of 5 mg given at this time instead of the ordered 20 mg dose]

On 7/14/21 at 1:43 PM an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 755	Continued From page 24	F 755		

conducted with the DON who stated it was her expectation that if an order was written then the nurse carry out the order as it is written. When asked if a medication was ordered to be given every 4 hours how many times a day and what times should it be given she responded well usually the pharmacy would print out the times on the MAR unless the doctor specified times. When asked if it was usual practice for nurses to hold medicine because a resident is asleep and she said no.

On 7/14/21 at 1:55 PM an interview was conducted with the unit manager who was asked what the nurses were expected to do if they held a medication, and she stated that the nurses were expected to call the provider and the RP and document why a medication is being held or not given.
She was asked to explain the process of ordering a refill of narcotics and she stated that it depended if it was scheduled or PRN (as needed). When she was told a scheduled narcotic she stated that usually the nurse would reorder the medication when there were a few doses left to give the pharmacy time to get it to the facility. She also stated that "If a hard script is needed by the pharmacy we expect the nurses to call the provider to get it sent over to the pharmacy.' She stated this is usually not a problem because the PA (physician's assistant) is usually in the building every day except Thursday. The unit manger stated that it was her expectation that if a medication was not available to give a Resident the nurses should check the stat box, if its not in the stat box, notify the pharmacy, phone the physician to see if he wanted to change the order to something similar that we have in the stat box , notify the Resident

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F 755	Continued From page 25	F 755		

or RP and document all of it in the chart.

On 7/15/21 during the end of day conference the Administrator was made aware of the concerns and no new information was provided.

2. For Resident #51 the facility staff failed to ensure that the

For Resident # 26, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable.

Findings included:

1. For Resident # 26, the facility staff failed to ensure medications were available for administration as ordered by the Physician.

Resident # 26 was a 62 year old male admitted to the facility on 7/10/2019 with the diagnoses of, but not limited to, Diabetes, Peripheral Vascular Disease, Chronic Pancreatitis, Spinal Stenosis, History of Basal Cell Carcinoma, Posterior Upper Trunk Soft Tissue Mass and Morbid Obesity.

Resident #26's most recent Minimum Data Set (MDS) was a Significant Change assessment with an Assessment Reference Date (ARD) of 5/24/2021. The MDS coded Resident # 26 with a