PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments 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.	
A BUILDING A 95189 A 95189 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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.	
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	
REGENCY HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments 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.	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	
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.	(X5) DMPLETION DATE
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.	
SS=E CFR(s): 483.73(b)(1)	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.	6) DATE

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

08/06/2021

PRINTED: 08/12/2021

Electronically Signed

PRINTED: 08/12/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ C B. WING 07/15/2021 495189 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 112 N CONSTITUTION DR REGENCY HEALTH AND REHABILITATION CENTER GRAFTON, VA 23692 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 The statements made in the following Based on staff interview and facility plan of correction are not an admission to documentation review, the facility staff failed to and do not constitute an agreement with obtain contractual agreements to ensure provisions for food, water, sewage, and

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:

disposable services during an emergency.

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 allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IMPED:	TIPLE CONSTRUCTION NG	(X3) DATÉ SURVEY COMPLETED
	495189	B. WING		C 07/15/20<u>2</u>1
NAME OF PROVIDER OF	R SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
REGENCY HEALTH	AND REHABILITATION CENTE	≣R	112 N CONSTITUTION DR GRAFTON, VA 23692	
PREFIX (EACH	JMMARY STATEMENT OF DEFICIENCI DEFICIENCY MUST BE PRECEDED B ATORY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE

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

F015

- 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
- 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.

PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

		WAY BROWER FOR IRRUST IN THE PARTY IN	(VO) MILL T	TIPLE CONSTRUCTION	(X3) DATE SURVEY		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COMPLETED		
		I	1 (2) 10 11 11		· c		
		495189	B. WING _		07/15/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	VIII AND DELL	A DU ITATION CENTED	1	112 N CONSTITUTION DR			
REGENC	Y HEALIH AND KEH	ABILITATION CENTER		GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
E 015	Continued From pa	age 3	E 0	15			
2010	container to be deli waste capacity unti can resume norma	vered to be used for extra I the contracted waste vendor I operations." There were no nents with these companies			,		
	presented 4 documentitled, "Dietary Dietary and "Photon the page was ewith the subtitle, "Tequipment is on the chart had three column and "No." Docume Name] Preparedness and Technology and Color Dietary	t a contractual agreements, the ed that document number 23 use out of a contract but a					
	notified of concerr agreements for for disposal. By the en	:35 PM, the administrator was as for lack of contractual od, water, sewage, and and of survey, the administrator er documentation or					
		LTC Emergency Power	E	041	8/23/21		

		AND HUMAN SERVICES & MEDICAID SERVICES		FORM A OMB NO. 0	PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION (X3) DATE COMP	SURVEY
*		495189	B. WING	i i i i i i i i i i i i i i i i i i i	5/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
REGENC	Y HEALTH AND REH	ABILITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692	. <u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) COMPLETION DATE
E 041	Continued From pa	age 4	E 0	041	
	(e) Emergency and hospital must imple power systems bas forth in paragraph policies and proceed paragraphs (b)(1)(i) §483.73(e), §485.6 (e) Emergency and [LTC facility and the emergency and states.	on for Participation: I standby power systems. The ement emergency and standby sed on the emergency plan set (a) of this section and in the dures plan set forth in) and (ii) of this section. [25(e) I standby power systems. The e CAH] must implement andby power systems based on n set forth in paragraph (a) of			
	Emergency general must be located in requirements foun Code (NFPA 99 and Code)	3.73(e)(1), §485.625(e)(1) ator location. The generator accordance with the location d in the Health Care Facilities and Tentative Interim 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

Facility ID: VA0192

PRINTED: 08/12/2021 *DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ C B WING 07/15/2021 495189 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 112 N CONSTITUTION DR REGENCY HEALTH AND REHABILITATION CENTER GRAFTON, VA 23692 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 041 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):1 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

(ii) Technical interim amendment (TIA) 12-2 to

(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.

edition, issued August 11, 2011.

NFPA 99, issued August 11, 2011.

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 08/12/ FORM APPRO OMB NO. 0938-	OVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		40.54.00	D WINC		C	
		495189	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/15/202 <u></u>	
	ROVIDER OR SUPPLIER			112 N CONSTITUTION DR		
REGENC	Y HEALTH AND REH	ABILITATION CENTER		GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPL	ETION
E 041	Continued From pa	ane 6	E 0	41		
E 041	(vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-2 to NF 2012. (x) TIA 12-3 to NFF 2013. (xi) TIA 12-4 to NF 2013.	Safety Code, 2012 edition,	_ 0			
	Standby Power Sy TIAs to chapter 7, This REQUIREME by:	stems, 2010 edition, including issued August 6, 2009 NT is not met as evidenced				
	obtain contractual generator will remain emergency.	riew, the facility staff failed to agreements to ensure the ain operational during an		E041 1- The Administrator obtained a contractual agreement with the diesel fuel vendor that provides during an emergency. A copy of contract is available for view in	e generator s services of the the	
	surveyor and the a facility's emergend was asked about t keep the generato emergency, the Ad following 2 docum	approximately 3:30 P.M., this administrator reviewed the by plan. When the administrator the emergency plan for how to be reperational during an administrator presented the		Emergency Preparedness plar 2- The Administrator will review Emergency Preparedness plar that contracts are in place and 3- The Administrator has refere Emergency Preparedness poli procedures to include the need contractual agreements in place date. 4- The Administrator will review Emergency Preparedness plan annual basis to ensure that the	w the in to ensure up to date. enced the cies and d to have ce and up to w the in on an	
	facility has an on-	site diesel fuel tank for the		contracts that provide services	to ensure	

emergency power generator. This fuel tank is

regulations. The Maintenance Director closely

monitors facility diesel fuel tank levels. In the

event of an emergency that requires emergency

verified to be in accordance with NFPA

that the generator is operational in the

to date. Results of the audit will be

review and recommendations.

presented to the QAPI committee for

event of an emergency is in place and up

			HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 08/12/2021 M APPROVED O. 0938-0391
-	STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION		ATE SURVEY OMPLETED
			495189	B. WING		TO CODE		C 7/15/2021
	NAME OF PR	ROVIDER OR SUPPLIEF	!			REET ADDRESS, CITY, STATE, ZIP CODE 2 N CONSTITUTION DR		
	REGENCY	HEALTH AND RE	HABILITATION CENTER			RAFTON, VA 23692		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
			page 7 the Maintenance Director will fuel provider to notify of the	ΕC	141	5- Completion date 8/23/21.		
		documented the f emergency power name] is available refueling. Please needed." The doc vendor sales repr The was no contr	tled "Letter of Intent" ollowing: "In the event of an generator use, [company to assist with diesel tank call [number] when services are ument was signed by the esentative and dated "1-19-21". actual agreement with the fuel by the administrator.					
	F 000	notified of concer agreements for re event of an emerg	4:35 PM, the administrator was ns for lack of contractual efueling their generator in the gency. By the end of survey, the mitted no further documentation	ı	000			
		standard survey v through 7/15/202 compliance with 4 Term Care requir survey/report will (VA00050645 - s	Medicare/Medicaid Abbreviated was conducted 7/13/2021 1. Corrections are required for 42 CFR Part 483 Federal Long ements. The Life Safety Code follow. One complaint ubstantiated without deficiency) during the survey.	i				· · · · · · · · · · · · · · · · · · ·
		at the time of the consisted of 21 F	is 60 licensed bed facility was 53 survey. The survey sample Resident reviews. d Meet Professional Standards b)(3)(i)		658			8/23/21
		§483.21(b)(3) Co	omprehensive Care Plans					

PRINTED: 08/12/2021 FORM APPROVED

OENTER	O FOR MEDICARI				OMB NO. (1938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	TIPLE CONSTRUCTION	(X3) DATE	LETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	I	
					С	1
	•	495189	B. WING			5/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII	P CODE	
			1	112 N CONSTITUTION DR		
REGENC	Y HEALTH AND REF	ABILITATION CENTER		GRAFTON, VA 23692		
	OUR MARK OF	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
(X4) ID PREFIX	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	X (EACH CORRECTIVE ACT)	ION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T		DATE
				DEFICIENC		
F 658	Continued From p	age 8	F 6	558		
	•	ided or arranged by the facility,				
		comprehensive care plan,				
:	must-	Compression a case prainty				
		nal standards of quality.				
	This REQUIREME	NT is not met as evidenced				
	by:		•			
	Based on observa	ation, Resident interview, staff		F658		
		cal record review, the facility		1-The Licensed nurses i		
		ide services in accordance with		documentation error invo	olving Resident #2	
	professional stand	lards of practice for 2 Residents		were educated on proper	r medication	
	(Resident #2 and	Resident #8), in a survey		administration document		
	sample of 21 Resi			#2 has been assessed b		
				receiving medication to r		
	1. For Resident #2	2 the facility staff failed to		Diabetes. A clarification of		
1	document the adn	ninistration of Byetta insulin as		received for Resident #8	, which specifies	
	ordered by the phy	ysician. The facility staff		to wake the resident for t		
	documented the a	dministration of Bydureon		of Oxycodone if he is sle	eping, per the	
	insulin, despite thi	is order being discontinued.		resident⊡s request.		
	• •	•		2- All residents receiving	medications are	
	2. For Resident #8	8 the facility failed to give		at risk for deficient practi	ce related to the	
	Oxycodone 20 mg	g every four hours as ordered by	1	need for proper administ	ration and	
	the physician, and	failed to document why		documentation of medical		
	medications were	held.		or designee will complete		
				residents receiving Insul		
				pain medication to ensur		
	The findings inclu	ded:		residents are receiving t		
				medication as ordered a		
	1. For Resident #	2 the facility staff failed to		medications are held that		
	document the adr	ministration of Byetta insulin as		evidence documented w	ny a medication	
	ordered by the ph	ysician. The facility staff		was held.	t Coordinator will	
		administration of Bydureon		3-The Staff Developmen		
	insulin, despite th	is order being discontinued.		educate licensed Nurses		
				Medication Administration		
		admitted to the facility 10/15/20.		documentation of reason		
	Diagnosis for Res	sident #2, included but were not		omission or medications		
	limited to: hemiple	egia affecting left non-dominant		4-The Unit Manager or o	resignee will	

stage 3b.

side, sepsis, type 2 diabetes with diabetic

polyneuropathy, and chronic kidney disease

complete audits of residents receiving Insulin and routine pain medication to

ensure that the residents are receiving the

PRINTED: 08/12/2021 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SEKVICES			JIVID 140. 0000 000
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	B. WING		C 07/15/2021
NAME OF PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
REGENCY HEALTH AND REH	ABILITATION CENTER	''-	2 N CONSTITUTION DR RAFTON, VA 23692	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 658 Continued From pa	go 0	F 658		4

ooo Continued From page 9

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.

PRINTED: 08/12/2021 EODM ADDROVED

		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495189	•		C 07/15/2021
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00,202.
REGEN	NCY HEALTH AND REH	ABILITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 65	During the morning of Nursing (DON) (Consultant (Emplo (Employee F), and Preventionist (Employee roman) did not appear to hemotic for the control of the con	age 10 sugars four times daily. g of 7/15/21, the facility Director Employee B), Nurse yee E), Unit Manager Registered Nurse/Infection ployee K) were notified that the ge on 5/27/21, for Resident #2 ave been carried out. They ware that it appeared Resident	F 6	58	

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".

#2 had continued to receive the insulin that had been ordered to stop due to his chronic kidney

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

disease.

PRINTED: 08/12/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ С 07/15/2021 B. WING 495189 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 112 N CONSTITUTION DR REGENCY HEALTH AND REHABILITATION CENTER GRAFTON, VA 23692 PROVIDER'S PLAN OF CORRECTION (X5) ID SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 658 F 658 Continued From page 11 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

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u>омв ио.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COM	E SURVEY IPLETED
		495189	B. WING			C 15/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	112 N CONSTITUTION DR		ľ
REGENC	Y HEALTH AND REH	ABILITATION CENTER		GRAFTON, VA 23692	_,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	Continued From pa	age 12	F 65	58		
	or harm clients." Guidance is given "Safe Medication A General" 10/02/20 administered in the (Electronic Medica a medication wash reason why, any in notification, and th interventions." Additional Guidanc Center.com (www. Rights of Medicatio 1. Right patient. Of and the patient. Us identify himself/he technology (for exc.) 2. Right medicatio Check the order. 3. Right dose. Ch appropriateness or reference. If neces have another nurs 4. Right route. Ag appropriateness of that the patient ca medication by the 5. Right time. Che medication. Doubloordered dose at th the last dose was 6. Right documen administration AF medication. Chart the time, ro information as ne of an injection or a	from Lippincott Solutions, administration Practices, and 15. "Document all medications e patient's MAR or EMAR tion Administration Record). If 't administered, document the terventions taken, practitioner e patient's response to be from Lippincott's Nursing nursingcenter.com) on Administration theck the name on the order se 2 identifiers. Ask patient to reelf. When available, use ample, bar-code system). In Check the medication label. The dose using a current drug sary, calculate the dose and the calculate the dose as well. The aim, check the order and the route ordered. Confirm thake or receive the ordered route. The ordered route ordered the correct time. Confirm when the correct time. Confirm when	١			

Facility ID: VA0192

	MENT OF HEALTH AN						0. 0938-0391
STATEMENT	S FOR MEDICARE & I OF DEFICIENCIES F CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DA	MPLETED
		407400	B. WING			٥.	C 7/15/2021
	ROVIDER OR SUPPLIER Y HEALTH AND REHABI	495189 LITATION CENTER	B. WING	STREE	ET ADDRESS, CITY, STATE, ZIP CODE CONSTITUTION DR FTON, VA 23692	U i	7/19/2021
		ENT OF DEFICIENCIES	ID	- GIVA	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOUNDS: CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 658	Why is he/she taking treasons for long-term 8. Right response. Mathe desired effect. If an given, has his/her blood Does the patient verbadepression while on an to document your morany other nursing interapplicable. Reference: Nursing 20 Lippincott Williams & Pennsylvania. The facility Administration of interactions and the Administration of interactions and the Administration of interactions.	In the rationale for the What is the patient's history? This medication? Revisit the medication use. The same that the drug led to an antihypertensive was add pressure improved? The same improvement in antidepressant? Be sure ditoring of the patient and eventions that are 12 Drug Handbook. (2012). Wilkins: Philadelphia, the failure to document ansulin ordered for Resident imentation of administration.	F 6	58			
	No further information	was provided.					1
	2. For Resident #8, the ensure medications wordered by the physic						
	Resident # 8, a 68 yr. facility on 3/11/20 with limited to esophageal	old male admitted to the diagnoses of but not cancer, anxiety,					

PRINTED: 08/12/2021

PRINTED: 08/12/2021 FORM APPROVED

		AND HOWAN SERVICES				OMB NO	. 0938-0391
		& MEDICAID SERVICES	(Y2) MI II T	PLE CONSTRU	CTION		E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IG		COV	MPLETED C
		495189	B. WING _				/15/202 <u>1</u>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE		
DEOENG	NAME AND DEL	IADII ITATION CENTED	i		TITUTION DR		
REGENC	Y HEALIH AND REF	IABILITATION CENTER		GRAFTON,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC' CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658		_	F 6	58			
	depression, COPL), malignant neoplasm of osis of liver, chronic pain related					
	to cancer, and cal	culus of gallbladder and bile					
	duct (gall stones s	till present in gall bladder and					
	bile duct) with acu	te and chronic cholecystitis.					
	The most recent N	IDS was a Quarterly with an					
	ARD of 4/14/21.	Resident #8 was coded as					
	having a BIMS (B	rief Interview of Mental Status)					
	score of 15 indica	ting no cognitive impairment. ded as being independent with					
	most ADI 's with the	ne exception of eating as he has	3				
	a peg tube that is	being used to supplement his					
	diet, as he has iss	sues maintaining an ideal body					
	weight due to the	diagnosis of cancer. He can					
	ambulate indeper	idently but uses a wheel chair					
	for mobility on uni	t due to ratigue.					•
	On 7/14/21 during	g clinical record review revealed					
	that Resident #8's	s physicians order read:					
	Oxycodone 20 mg	g. Immediate Release give 1					
	tablet every four h	nours. [Per MAR the Scheduled	1				
	6:00 PM, 10:00 P	M, 6:00 AM, 10:00 AM, 2:00 PN Mi	1,				
	0.00 FW, 10.00 I	141]					
	A review of the M	AR (medication administration					
	record revealed t	he resident missed 25 doses of					
	scheduled pain m	nedication between 5/24/21 and					
	7/14/21 they - are	e as follows:					
	05/24/21 - 2:00 A	M dose - Signed off in MAR as					
	#7 - sleeping- No	progress note in chart.					
	05/29/21 - 10:00	PM dose - not signed off on					
1	MAR, signed out	in Narc book no progress note					

not given coded as #7 Sleeping

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

06/13/21 - 2:00 AM dose - MAR signed off not

ACNT OF BEALTH AND HIMAN SERVICES

PRINTED: 08/12/2021 FORM APPROVED

		AND HUMAN SERVICES					O. 0938-0391
CENTER	<u>IS FOR MEDICARI</u>	E & MEDICAID SERVICES	T				
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		ATE SURVEY OMPLETED
		•					Ċ
		495189	B. WING			0	7/15/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	12 N CONSTITUTION DR		
REGENC	Y HEALTH AND REI	HABILITATION CENTER		G	GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
:							
F 658	Continued From p		F 6	358	}		
	given coded as #7 06/14/21- 2:00 AN given coded as #7 06/18/21 - 2:00 AN given coded as #7 06/19/21 - 2:00 AN given coded as #7 06/20/21 - 6:00 P given coded as #7 06/20/21 - 6:00 P given coded as #7 06/20/21 - 2:00 AN given coded as #7 06/22/21- 2:00 AN given coded as #7 06/28/21- 2:00 AN given coded as #7 07/01/21- 2:00 AN given coded as #7 07/02/21- 2:00 AN given coded as #7 07/03/21- 2:00 AN given coded as #7 07/03/21- 2:00 AN given coded as #7 07/04/21- 2:00 AN given coded as #7 07/04/21- 2:00 AN given coded as #7 07/06/21- 2:00 AN given coded as #7 07/06/21- 2:00 AN given coded as #7 07/06/21- 2:00 AN given coded as #7 07/07/21- 2:00 AN given coded as #7 07/06/21- 2:00 AN given coded as #7 07/06/21- 2:00 AN given coded as #7 07/07/21-	7 - Sleeping M dose - MAR signed off not 7 Sleeping M dose - MAR signed off not 7 Sleeping M dose - MAR signed off not 7 Sleeping M dose - MAR signed off as not 5 see nurses note. Progress 1/2021 20:07 Orders - 1/2021 20					
	07/07/21- 2:00 A given coded as a 07/09/21- 6:00 F given coded as a Progress notes.	AM dose - MAR signed off not #7 - Sleeping					

space blank. Narcotics book does not reflect medication being given. No progress note to

PRINTED: 08/12/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 07/15/2021 495189 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 112 N CONSTITUTION DR REGENCY HEALTH AND REHABILITATION CENTER GRAFTON, VA 23692 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 658 F 658 Continued From page 16 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 PM1 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 HCI 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

issue as well."

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

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

PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

CENTERS FO	OR MEDICARE	: & MEDICAID SERVICES			Olvio I	10. 0000 000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		495189	B. WING _			07/15/202 <u>1</u>
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
REGENCY HE	ALTH AND REH	ABILITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692		
(X4) ID PREFIX TAG F	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
: - :				,		

F 658 : Continued From page 17

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

F 658

PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES			<u>VID IVO. 0930-039</u>		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495189			C 07/15/202 <u>1</u>		
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTH AND REHABILITATION CENTER			i .	STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR GRAFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
1							

F 658 Continued From page 18

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,

F 658

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM A OMB NO. (APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	1	PLETED
		495189	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		5/202 <u>1</u>
	ROVIDER OR SUPPLIER		,	112 N CONSTITUTION DR		
REGENC	Y HEALTH AND REH	IABILITATION CENTER		GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		OULD BE	(X5) COMPLETION DATE
F 755	Nursing Scope and of (2004), apply to administration. To follow the six rights medication errors an inconsistency in medication adminimedication administration was and no new informore Pharmacy Srvcs/CCFR(s): 483.45 (as §483.45 Pharmacy Srvcs/CCFR(s): 483.45	can Nurses Association's distandards of Nursing Practice the activity of medication prevent medication errors, is of medications. Many can be linked, in some way, to adhering to the six rights of estration. The six rights of estration include the following: attion attion the end of day conference the ended aware of the concerns mation was provided. Procedures/Pharmacist/Recordity(b)(1)-(3) by Services provide routine and emergency cals to its residents, or obtain greement described in facility may permit unlicensed	ls F	755		8/23/21
	personnel to adm permits, but only a licensed nurse.	ninister drugs if State law under the general supervision of	of			

Event ID: Z5W611

PRINTED: 08/12/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495189 B. WING 07/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 112 N CONSTITUTION DR REGENCY HEALTH AND REHABILITATION CENTER GRAFTON, VA 23692 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 755 Continued From page 20 F 755 §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 Based on observation, interview, facility F755 documentation and clinical record review, the 1-Resident #36, 51 and 26 all have medications available for administration. facility staff failed to provide routine medications to 4 Residents (#'s 8, 36, 51, and 26) in a Survey Resident #8 has an adequate supply of Oxycodone and is receiving the sample of 21 Residents.

The Findings included:

1. For Resident #8 the facility staff failed to

ensure he had an adequate supply of routinely

Resident # 8, a 68 yr. old male admitted to the

facility on 3/11/20 with diagnoses of but not

scheduled oxycodone (narcotic pain medication).

medication as prescribed.

and proper administration and

2- All residents receiving medications are

at risk for deficient practice related to the need for availability of the medications

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

PRINTED: 08/12/2021 FORM APPROVED AMB NO 0038 0301

CENTERS	S FOR MEDICARE	E & MEDICAID SERVICES			OIVID IV	<u>J. 0930-039 I</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495189	B. WING _		0.	C 7/15/202 <u>1</u>
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Æ	
REGENCY	HEALTH AND REF	IABILITATION CENTER		112 N CONSTITUTION DR GRAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	Continued From p	nge 21	F 75	55		

Continued From page 21

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 HCI 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.

PRINTED: 08/12/2021 FORM APPROVED OMB NO 0938-0391

CHINIEL	12 LOV MEDICAKE	A MEDICAID SERVICES				CIVID NO	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	COV	E SURVEY MPLETED
		495189	B. WING			07	C /15/202 <u>1</u>
NAME OF F	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
REGENC	Y HEALTH AND REF	IABILITATION CENTER		'''	CONSTITUTION DR TON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPL	OULD BE	(X5) COMPLETION DATE
F 755	Continued From page	age 22	F ?	755			
	•	ence. "Resident outside"					
		dose - MAR signed off not					1
	given coded as #9 Progress notes.	- Other see progress notes					•
		entered for time to explain not					
	space blank. Narc	M dose - MAR not signed off otics book does not reflect given. No progress note to was held.					
	Narcotics sign out oxycodone being u	7/9/21 a new card was not					
	nothing was signe	I dose - MAR was left blank d out in the Narcotics book and s were found in the progress	I				
	Incorrect Docume HCI Tablet 5 MG (hours as needed t PSR 4-10; may gi IThe nurse gave F	M Orders - Administration Note ntation - Note Text: Oxycodone Give 1 tablet by mouth every 4 for moderate to severe pain ve per PEG per pt. preference. Resident #8 his PRN dose of 5 routine 20 mg ordered for 2					•
	this dose nothing	A dose - MAR was left blank for was signed out in the Narcotics owing notes were found in the					:

progress note.

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

Facility ID: VA0192

PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-039					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		ONSTRUCTION		(X3) DATE COMP	SURVEY LETED
							С	
		495189	B. WING _				07/1	5/202 <u>1</u>
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIF N CONSTITUTION DR	CODE		
REGENC	Y HEALTH AND REH	ABILITATION CENTER			AFTON, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
	not given and code notes The progress "7/10/2021 09:36 C Text: oxycodone He by mouth every 4 h somnolence; may g "Resident not giver because it is not in	dose- MAR was signed off as d as #9 other see progress	F 75	55,				
		dose - MAR signed as not - other see progress notes. ad as follows:						1
	Text: oxycodone H by mouth every 4 h somnolence; may Medication not in f and aware that this this resident and the ASAP Unit manage	M Orders - Administration Note CI Tablet 20 MG Give 1 tablet nours for cancer pain hold for give via PEG per pt. preference acility. Pharmacy contacted is a scheduled medication for nat we will need it delivered ger also made aware, RN on by also made aware of same."						
	Text: oxycodone I- mouth every 4 hou severe pain PSR of preference PRN A	A Orders - Administration Note ACI Tablet 5 MG Give 1 tablet by urs as needed for moderate to 4-10; may give per PEG per pt. Administration was: Effective cale was: 5 [PRN dose of 5 mg instead of the ordered 20 mg	,					

PRINTED: 08/12/2021

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER	495189 IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 112 N CONSTITUTION DR GRAFTON, VA 23692	C 07/15/20<u>21</u> ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 755	expectation that if nurse carry out the asked if a medicate every 4 hours how times should it be usually the pharmathe MAR unless the When asked if it whold medicine because said no. On 7/14/21 at 1:58 conducted with the what the nurses we a medication, and were expected to and document who not given. She was asked to a refill of narcotic depended if it was needed). When a narcotic she state reorder the medication, and the facility. She aneeded by the pharmacy.' She problem because usually in the builthe unit manger expectation that to give a Reside stat box, if its not the said of the provider of the unit manger expectation that to give a Reside stat box, if its not the provider of the provider of the unit manger expectation that to give a Reside stat box, if its not the provider of the provider of the unit manger expectation that to give a Reside stat box, if its not the provider of the provide	age 24 a DON who stated it was her an order was written then the corder as it is written. When ion was ordered to be given many times a day and what given she responded well acy would print out the times on a doctor specified times. The assumal practice for nurses to ause a resident is asleep and as unit manager who was asked the expected to do if they held she stated that the nurses call the provider and the RP y a medication is being held or explain the process of ordering and she stated that it is scheduled or PRN (as she was told a scheduled at that usually the nurse would be also stated that "If a hard script is a hard script is a hard script is a stated this is usually not a set the PA (physician's assistant) is liding every day except Thursday at the nurses should check the it in the stat box, notify the neet the physician to see if he are the order to something similar the nurse of the order to something similar the nurse or to something similar the product of the something similar the nurse or to something similar the nurse or to something similar the product of	is o s y.		

wanted to change the order to something similar

PRINTED: 08/12/2021 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB N	O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495189				0	C 7/15/2021
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y HEALTH AND REH	ABILITATION CENTER			2 N CONSTITUTION DR RAFTON, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 755	On 7/15/21 during	age 25 Int all of it in the chart. The end of day conference the made aware of the concerns	F 7	55			
		ation was provided.					
	2. For Resident #5 ensure that the	1 the facility staff failed to					
	provide medication	, the facility staff failed to ns as ordered by the physician. vere listed as medication					
	Findings included						
	ensure medication as	26, the facility staff failed to ns were available for ordered by the Physician.					
	the facility on 7/1 but not limited to, Disease, Chronic History of Basal Trunk Soft Tissu	s a 62 year old male admitted to 0/2019 with the diagnoses of, Diabetes, Peripheral Vascular Pancreatitis, Spinal Stenosis, Cell Carcinoma, Posterior Uppee Mass and Morbid Obesity.	:r				
	Resident #26's	most recent Minimum Data Set					

(MDS) was a Significant Change assessment with an Assessment Reference Date (ARD) of