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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E131	A. BUILDING _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SW VA M H INST GERI TRT CTR	340 BAGLEY CIRCLE MARION, VA 24354

(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 An unannounced Emergency Preparedness survey was conducted 02/23/21 through 02/26/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/23/21 through 02/26/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 25 certified bed facility was 20 at the time of the survey. The final survey sample consisted of 12 current resident reviews and 2 closed record reviews.	F 000		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical document review, it was determined the facility staff failed to ensure a medication error rate of less than 5%. There were six (6) medication errors in 32 opportunities resulting in a medication error rate of 18.75%. (The residents involved in these medication errors were: Resident #14, Resident #4, and Resident	F 759		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deianna K Smith LCSW/LNHA	Director of Geriatric Services	03/26/2021

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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F 759	Continued From page 1	F 759		

#1.)

The findings include:

Medication errors were observed while completing the Medication Administration Task on the morning of 2/24/21. There were six (6) errors in 32 opportunities resulting in a medication error rate of 18.75%.

Resident #14's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/14/20, had the resident assessed as able to make self understood and as usually able to understand others. Resident #14's Brief Interview for Mental Status (BIMS) summary score was a 12 out of 15. Resident #14 was assessed as requiring limited assistance with transfers and supervision with eating and personal hygiene. Resident #14's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and Parkinson's disease.

Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/6/21, had the resident assessed as usually able to make self understood and as usually able to understand others. Resident #4's Brief Interview for Mental Status (BIMS) summary score was a seven (7) out of 15. Resident #4 was assessed as requiring supervision with dressing, eating, and toilet use. Resident #4's diagnoses included, but were not limited to: heart failure, coronary artery disease, and peripheral vascular disease.

Resident #1's minimum data set (MDS) assessment, with an assessment reference date

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F 759	Continued From page 2 (ARD) of 12/7/20, had the resident assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was a one (1) out of 15. Resident #1 was assessed as requiring supervision with bed mobility, eating, transfers, dressing, and toilet use. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, dementia, and lung disease. On 2/24/21 at 7:47 a.m., Licensed Practical Nurse (LPN) #1 was observed administering medications to Resident #14. The following three (3) medications were included in the medications provided to Resident #14 during this observation: (a) Metformin 1000 mg one (1) tablet by mouth, (b) humulin N insulin 35 units as a subcutaneous injection, and (c) levothyroxine 88 mcg one (1) tablet by mouth. These three (3) medications were administered after breakfast and without food. Resident #14's clinical record included the following orders: - insulin isophane (NPH) 35 units subcutaneous daily before breakfast; - levothyroxine 88 mcg one (1) tablet daily before breakfast; and - metformin 1000 mg one (1) tablet twice a day with meals. During an interview on 2/24/21 at 9:50 a.m., LPN #1 confirmed the aforementioned medications were given after breakfast. During an interview on 2/24/21 at 10:10 a.m., the facility's Unit Nurse Manager (UNM) reported the metformin should have been administered with food.	F 759		
		F759	Resident #14 and #4 Electronic Health Record (EHR) medication orders and EHR Medication Administration Records (MAR) were reviewed for medication administration times, before breakfast and with meals/food. Neither resident has r eceived medication after breakfast or without meal/food in interim of this review date.	02/24/2021
			Unit Nurse Coordinator conducted a review of EHR medication orders and MAR times for before breakfast and with meal/food for 100% of residents. EHR MAR times for administration of medication ordered before breakfast/ meal and with meal/food were corrected on the MAR.	02/24/2021
			Each L.P.N. and R.N. assigned to Ward E/F received an educational notification by the UNC with information to follow medication orders and MAR with administration of medications before breakfast and with meal/food.	02/24/2021
			The UNC developed a Geriatric Medication Administration audit tool for medication administration compliance for 100% of the residents. The audit will be a random sample of residents weekly.	03/19/2021

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F 759	Continued From page 3 On 2/24/21 at 8:03 a.m., LPN #1 was observed administering medications to Resident #4. LPN #1 was observed to give Resident #4 cinacalcet 30 mg one (1) tablet by mouth; this medication was not administered with food. Resident #4's clinical record included an order for cinacalcet 30 mg one (1) tablet by mouth with instructions to "Take With Food". On 2/24/21 at 08:07 a.m., LPN #1 was observed administering medications to Resident #1. LPN #1 was observed to crush the following medications prior to administering them to Resident #1: (a) Metoprolol ER 25 mg one (1) tablet and (b) paliperidone 3 mg one (1) tablet. The packaging of Paliperidone included the phrase "DO NOT CRUSH". On 2/24/21 at 12:50 p.m., Registered Nurse (RN) #5 provided a copy of a "Do Not Crush List" to the survey team; this document included Metoprolol ER tablet due to it being a sustained release medication. The following information was found in a facility policy/procedure with the subject of "Medication Administration" (with a review date of August 1, 2021): - "The medication nurse is responsible for ensuring the "6 Rights" (i.e., drug, dose, patient, route, time, and documentation)..." - "If medications are ordered by the medical professional to be crushed, the nurse administering medications is responsible to check the "Do Not Crush List" prior to crushing and administering medications." The aforementioned medication administration observations were discussed with the facility Unit	F 759	Monitoring to be sustained for six consecutive months of 100% compliance. Facility CNE is responsible for the implementation of this element of the Plan of Correction. Resident # 1 EHR medication orders and MAR was reviewed for medication ordered "DO NOT CRUSH". This resident has not received any unapproved "DO NOT CRUSH" medications in the interim of this review date. UNC conducted a review of EHR medication orders and MARs for "DO NOT CRUSH" medications for 100% of residents. Each L.P.N. and R.N. assigned to ward E/F received an educational notification by the UNC with information to follow the Facility "DO NOT CRUSH" medication list. The UNC developed a Geriatric Medication Administration audit tool for medication compliance for 100% of residents. The audit will be a random sample of residents weekly. Monitoring to be sustained for six consecutive months of 100% compliance. Facility CNE responsible for the implementation of this element of the Plan of Correction.	03/28/2021 & on going 04/01/2021 & on going 02/24/2021 02/24/2021 02/24/2021 03/19/2021 03/28/2021 & on going 04/01/2021 & on going

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F 759	Continued From page 4 Nurse Manager (UNM) on 2/25/21 at 4:30 p.m. These observations were also discussed with the facility's Administrator, UNM, and Director of Acute Treatment Services on 2/6/21 at 3:52 p.m.	F 759		