STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0127	A. BUILDING: _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILIFF NURSING AND REHABILITATION CENTER	8000 ILIFF DRIVE DUNN LORING, VA 22027

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 6-8-21 through 6-10-21. One complaint was investigated during the survey. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 114 bed facility was 83 at the time of the survey. The survey sample consisted of 9 resident reviews and 25 employee record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-220 (B) Nursing Services Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure medications were administered as prescribed by the physician for one of nine residents, Resident # 1. The findings included: For Resident # 1, the facility failed to ensure medications were not stored at the bedside. Flonase nasal spray and Venelex wound ointment were observed on the bedside table. On 6/9/2021 during morning rounds, a bottle of medication, Flonase nasal spray, was observed on the bedside table. There was also a tube of Venelex wound ointment on the bedside table. The observation was discussed with the Assistant	F 001	1. Corrective Action Resident #1 was affected by this deficient practice; facility removed medications at bedside and stored in a safe place and medication was given to residents husband and removed from the facility. 2. Other Potential Residents All geriatric residents have the potential to be affected by this deficient practice. 3. New Measures/System Changes Facility will educate all staff on the importance of giving charge nurse any medications found at bedside. Facility will include a notice in admission packet to inform families to notify administrator and director of nursing prior to bringing in medications from home so	7/23/21

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

Electronically Signed | 06/16/21

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F 001	Continued From page 1 Director of Nursing who also observed the medications on the bedside table. On 6/9/2021 at 10:58 a.m. Resident # 1 was not in the room. A container of generic brand nose spray in the box was observed on the bedside table along with tube of Venelex wound ointment. On 6/8/2021 at 11:00 a.m., with LPN (licensed Practical Nurse) A was interviewed. She stated "No ma'am I just gave her medicine earlier and put it in the cart." LPN A checked the cart and the medication was there in the medication cart, labeled and accounted for. Review of the resident clinical record revealed Resident #1 had physician orders for both Flonase and Venelex. Physicians Orders revealed documentation of orders dated 5/26/2021 for: Flonase (Fluticasone 50 MCG/ACT Suspension nasal spray 2 sprays in each nostril one time per day for seasonal allergy; and, Venelex ointment -Apply to sacrum topically every day and evening shift. Start 5/27/2021. LPN A was accompanied to Resident #1's room and LPN A found both items [Flonase (generic brand) bottle in the box with no Pharmacy label on bedside table along with tube of Venelex wound ointment] on the bedside table. LPN A stated that the "husband must have brought in the nasal spray but the Venelex was left there by the wound nurse." The ADON (Assistant Director of Nursing) were made aware of the issue. When asked if Resident #1 was able to self administer medications, he stated "No".	F 001	the facility can ensure that the resident receives an assessment for self-administration of medications and to ensure that the facility is aware of all medications being provided to residents . 4. Monitoring The DON or designee will complete visual observations on room rounding of all geriatric patient rooms to ensure there are no medications at bedside table. These visual observations will occur a minimum of 3 times a week and the results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 consecutive months. 5. Completion Date 07/23/2021	

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F 001	Continued From page 2 On 6/9/21, at approximately 11:00 a.m., the Assistant Director of Nursing stated Resident # 1 should not have the medication at the bedside. The Assistant Director of Nursing stated Resident # 1's husband brought the medication to the facility. On 6/9/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who stated she had been informed of the medication at the bedside. The Administrator stated Resident # 1 had not been assessed for self administration of medications and the medication should not have been left at the bedside. A copy of the facility policy on Self Administration was requested. On 6/10/2021 at 9:06 a.m., a copy of the policy on Self Administration was received and reviewed. The policy stated "Residents have the right to self administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Under Policy Interpretation and Implementation was written: 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering is clinically appropriate for the resident. 8. self administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self administer will be stored in a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident	F 001		

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F 001	Continued From page 3 when the resident requests them. 9. Staff shall give to the Charge Nurse any medications found at the bedside that are not authorized for self administration, for return to the family or responsible party. " On 6/10/2021 at 9:08 a.m., an interview was conducted with the Administrator. The Administrator stated medications should not be left at the bedside and that residents should be assessed to self administer medications. Nurses should keep medications in the medication room and administer them as prescribed by the physician. The families should not bring medications into the facility and leave them at the bedside. The Administrator and Director of Nursing were informed of the findings on 6/10/2021 during the end of day debriefing. No further information was provided.	F 001		