STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495207	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HEALTH AND REHABILITATION CENTER	720 ORCHARD AVENUE ROCKY MOUNT, VA 24151

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/20/2021 through 7/22/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/20/21 through 07/22/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. A complaint was investigated during the survey. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure the residents receive treatment and care in	F 684	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	9/8/21

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

Electronically Signed | 08/30/2021

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F 684	Continued From page 1 accordance with the comprehensive person-centered care plan for 1 of 26 residents in the survey sample, Resident #74. The findings included: For Resident #74, the facility staff administered a Vitamin C tablet instead of the physician ordered Cyanocobalamin (Vitamin B12) tablet. Resident #74's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Diastolic (Congestive) Heart Failure, Hypothyroidism Unspecified, Unspecified Dementia without Behavioral Disturbance, and Pulmonary Hypertension Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/22/21 assigned the resident a BIMS (brief interview for mental status) score of 7 out of 15 in section C, Cognitive Patterns. On 7/21/21 at 8:41 am, during a medication pass and pour observation, surveyor observed LPN (licensed practical nurse) #1 prepare and administer Resident #74's morning medications. LPN #1 administered a Vitamin C 1000 mg tablet to Resident #74. Surveyor reviewed Resident #74's current physician's orders and was unable to locate an order for Vitamin C. Surveyor noted a current physician's order dated 3/15/21 for Cyanocobalamin Tablet 1000 MCG by mouth one time a day for supplement. Surveyor did not observe LPN #1 administer a Cyanocobalamin 1000 mcg tablet with Resident #74's morning medications on 7/21/21. According to	F 684	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. F684 Quality of Care- 1. Facility Resident #74, the facility staff administered a Vitamin C tablet instead of the physician ordered Vitamin B12 tablet. 2.The Nurse Practitioner was made aware of the medication error on 8/25/2021. 3.An audit will be completed to ensure that the top of Vitamin C and Vitamin B12 bottlers are labeled. Medication observation passes will be completed by DON/HS/Unit Managers/SDC by 9/8/2021. 4.The SDC will give education to Licensed Nurses by 9/8/2021 regarding (5 rights) ensuring the correct drug is being administered during a medication pass. 5.Unit Managers/ House Supervisor/DON will audit medication carts 3-5x week to ensure Vitamin C and Vitamin B tops are labeled x 2months. Any noncompliance will be reported to the Administrator and DON and result in education and/or disciplinary action. Results of audits will be reviewed in QQA meeting for trending. 6.Date of completion : September 8, 2021	

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documentation on Resident #74's July 2021 MAR (medication administration record), LPN #1 initialed the MAR on 7/21/21 at 9:00 am for the administration of Cyanocobalamin 1000 mcg.

On 7/21/21 at 11:10 am, surveyor spoke with LPN #1 concerning Resident #74's being administered Vitamin C instead of the physician ordered Cyanocobalamin. LPN #1 opened the eMAR medication administration screen for Resident #74 and showed surveyor the computer screen and stated "baby (he/she) did get a Vitamin C". LPN #1 again looked at the eMAR screen and stated no the resident was given B12. Upon surveyor request, LPN #1 opened the drawer of the medication cart where the bottle of Cyanocobalamin was stored and surveyor observed the house stock medication bottles of Vitamin C 1000 mg and Vitamin B12 1000 mcg were located side by side in the drawer.

Resident #74's current care plan included a focus area stating "Nutrition Risk at admission r/t (related to) recent hospitalization, diuretic therapy, poor appetite and po (oral) intake and actual weight loss" with interventions stating "administer medication per MD order" and "provide diet and supplements as ordered".

During a meeting the administrator, director of nursing, and the regional nurse consultant on 7/21/21 at 3:28 pm, surveyor discussed the concern of Resident #74 receiving Vitamin C instead of the physician ordered Cyanocobalamin.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/22/21.

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that residents were free of significant medication errors for 1 of 26 residents in the survey sample, Resident #50. The findings included: For Resident #50, the facility staff failed to follow physician's orders for the administration of Novolog (a rapid-acting insulin) on 21 separate occasions. Resident #50's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus with Other Diabetic Ophthalmic Complications, Chronic Diastolic (Congestive) Heart Failure, Polyneuropathy Unspecified, and Chronic Pain Syndrome. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 6/08/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #50 was coded for the diagnosis of Diabetes Mellitus. Resident #50's current physician's orders included the following orders each dated 11/30/20: Novolog Solution 100 unit/ml inject 38 units subcutaneously one time a day for DM	F 760	F760 Residents free of significant med errors 1.The facility staff failed to follow physician's orders for Resident #50, the administration of Novolog (a rapid-acting insulin) on 21 separate occasions. 2.The Nurse Practitioner was made aware of the medication error on 7/21/2021. 3.An audit will be completed on sliding scale Novolog insulin to ensure compliance of Physician's orders by 9/8/21. 4.The SDC will give education to licensed nurses regarding Novolog administration by 9/8/2021. 5.Unit Managers/ House Supervisor/DON will audit SSI orders 3-5x week to ensure x 2 months to ensure Novolog is being administered per physician's orders. Any noncompliance will be reported to the Administrator and DON and result in education and/or disciplinary action. Results of audits will be reviewed in QQA meeting for trending. 6. Date of completion: September 8, 2021	9/8/21

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F 760	Continued From page 4	F 760		

(diabetes mellitus) hold for blood sugar < 140 scheduled on MAR (medication administration record) to be administered at 9:00 am, Novolog Solution 100 unit/ml inject 38 units subcutaneously one time a day for DM hold for blood sugar < 140 scheduled on MAR to be administered at 12:00 pm, and Novolog Solution 100 unit/ml inject 38 units subcutaneously one time a day for DM hold for blood sugar < 140 scheduled on MAR to be administered at 5:00 pm.

A review of Resident #50's July 2021 MAR revealed Resident #50 received Novolog 38 units with a documented blood sugar below 140 on 21 separate occasions as documented below:
7/01/21 9:00 am received with BS (blood sugar) of 125
7/03/21 9:00 am received with BS of 123
7/04/21 9:00 am received with BS of 135
7/04/21 5:00 pm received with BS of 106
7/05/21 9:00 am received with BS of 99
7/06/21 9:00 am received with BS of 91
7/07/21 9:00 am received with BS of 101
7/07/21 5:00 pm received with BS of 101
7/08/21 9:00 am received with BS of 104
7/08/21 5:00 pm received with BS of 129
7/09/21 5:00 pm received with BS of 137
7/10/21 5:00 pm received with BS of 103
7/11/21 12:00 pm received with BS of 137
7/14/21 9:00 am received with BS of 118
7/15/21 9:00 am received with BS of 124
7/16/21 12:00 pm received with BS of 136
7/17/21 9:00 am received with BS of 107
7/17/21 12:00 pm received with BS of 116
7/18/21 9:00 am received with BS of 124
7/19/21 9:00 am received with BS of 125
7/20/21 9:00 am received with BS of 115

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On 7/21/21 at 12:15 pm, surveyor spoke with the RNC (regional nurse consultant) and discussed the concern of Resident #50 receiving Novolog with documented blood sugars less than 140. The RNC stated they would look into this concern. At approximately 1:45 pm, the RNC returned and stated the insulin was held some of the times and documented in the progress notes but the MAR was signed off as if it were given, also stated they are contacting the physician concerning the order. Surveyor reviewed Resident #50's July 2021 progress notes and was unable to locate documentation of Novolog being held on the aforementioned occasions when the BS was less than 140 and the Novolog was initialed on the MAR as being given.

Resident #50's current care plan included a focus area stating "The resident has Diabetes Mellitus" with an intervention stating "Diabetes medication as ordered by doctor ..."

On 7/21/21 at approximately 3:15 pm, surveyor met with the administrator, director of nursing, and the RNC and discussed of concern of Resident #50 receiving Novolog with a BS below 140 on 21 separate occasions and surveyor was unable to locate documentation in the progress notes of the Novolog being held on these occasions.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/22/21.