STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 11/30/21 through 12/02/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 11/30/21 through 12/02/21. One complaint [VA00052006 -unsubstantiated] was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 312 certified bed facility was 193 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 2 closed record 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 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 staff interviews, clinical record review, facility document review, and during a medication pass and pour observation, it was determined the facility staff failed to provide services to meet	F 658	Resident #119□s medications are administered correctly then documented on the MAR, 12/3/2021.	1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/14/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 1 professional standards of practice for one (1) of four (4) residents observed during the Medication Administration Facility Task, (Resident #119). The findings included: A facility staff member, LPN (licensed practical nurse) #21, documented they had provided Resident #119 with two (2) medications that had not been administered. Resident #119's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/18/21, was documented as completed on 11/1/21. Resident #119 was coded as being able to make them self understood and as able to understand others. Resident #119's Brief Interview for Mental Status (BIMS) summary score was coded as 12 out of 15 (this indicated intact/borderline cognition). Resident #119 was coded as requiring limited assistance with bed mobility, transfers, eating, and personal hygiene. Resident #119's diagnoses included, but were not limited to: anemia, high blood pressure, thyroid disease, arthritis, and multiple sclerosis (MS). On 12/1/21 at 7:49 a.m., LPN #21 was observed to prepare and administer medications to Resident #119. During the observation LPN #21 was not observed administering Resident #119's nasal spray and topical pain medication. Both the nasal spray and the topical pain medication were scheduled to be administered at 8:00 a.m. Resident #119's clinical record included the following current medical provider orders: - An order dated 10/8/19 for "VOLTAREN 1% GEL; APPLY 2GMS TOPICALLY TO RIGHT SHOULDER (four times a day) FOR PAIN" and	F 658	LPN #21 will receive education on correct medication administration and documentation by the Staff Development Coordinator. The Director of Nursing will ensure compliance.12/8/2021 All LPN□s and RN□s responsible for administering and documenting medications will be in serviced on correct medication administration procedure by the Staff Development Coordinator. The Director of Nursing will ensure compliance. 12/30/2021 A 100% audit (see attached form) will be conducted by the Pharmacist and/or RN Nurse Managers of all nurses who administer medications to ensure correct medication administration and documentation. The Director of Nursing will ensure compliance. 12/30/2021 Quarterly 20 % of all nurses who administer medications will be audited by the Pharmacist and/or RN Nurse Managers to ensure correct medication administration and documentation. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken, The Director of Nursing will ensure compliance.1/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 2	F 658		

- An order dated 4/16/19 for "SALINE 0.65% NASAL SPRAY, ADMINISTER 2 SPRAYS EACH NOSTRIL (twice a day) FOR ALLERGIES"

Resident #119's medication administration records (MARs) were reviewed on 12/1/21 at approximately 9:30 a.m. It was noted that LPN #21 had documented they had administered Resident #119's 8:00 a.m. doses of saline nasal spray and Voltaren topical pain medication. On 12/1/21 at 9:36 a.m., LPN #21 was interviewed about the documentation indicating they had administered Resident #119's saline nasal spray and Voltaren topical gel. LPN #21 confirmed they had not administered either medication to Resident #119. LPN #21 reviewed Resident #119's MARs and reported both the saline nasal spray and Voltaren gel had been documented as being administered. LPN #21 reported they should not have documented those medications had been administered. LPN #21 obtained Resident #119's nasal spray from the medication cart and reported they would administer the nasal spray now. LPN #21 stated they had planned to wait until after the resident was bathed to administer the topical pain medication.

The following information was found in Pharmacology for Nurses: A Pathophysiologic Approach 3rd Edition (2011, page 21): "Once medications are administered, the nurse must correctly document that they have been given to the patient and this documentation is completed only after the medications have been given, not when they are prepared."

The following information was found in a facility policy/procedure titled "MEDICATION ADMINISTRATION" (this document did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	**2526 NORTH MAIN STREET DANVILLE, VA 24540**

(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 3 contain a date): "PREPARATION AND CHARTING ... E. RECORD IMMEDIATELY." On 12/1/21 at 4:08 p.m., the Assistant Administrator reported the facility did not have a policy/procedure that specifically addressed medications not being documented as administered prior to actually being administered to the resident. The following information was found in a facility policy/procedure titled "DOCUMENTATION OF NURSING CARE" (this document did not contain a date): "It is the policy of this facility to keep an accurate record of each resident's care, his/her condition and progress in the EMR (electronic medical record) ... the MAR (medication administration record) must be signed electronically by the nurse giving medications or treatments. If not given, document the reason not given on the MAR." On 12/1/21 at 3:32 p.m., the Director of Nursing (DON) and Infection Preventionist (IP) was interviewed about the aforementioned MAR documentation of Resident #119's medications being documented as given when the medication had not yet been administered. The DON reported that medications should not be signed as given prior to the medications being administered to the residents.	F 658		
F 759 SS=D	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;	F 759		1/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 759	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review, and during a medication pass and pour observation, it was determined the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) errors in 27 opportunities for a medication error rate of 7.41%. These medication errors affected Resident #119. The findings included: LPN (licensed practical nurse) #21 failed to administer Resident #119's ordered "SALINE 0.65% NASAL SPRAY" (this nasal spray was ordered by a medical provider due to allergies). LPN #21 attempted to administer an incorrect dose of Betaseron injection to Resident #119. (Betaseron is a medication used to treat multiple sclerosis (MS).) Resident #119's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/18/21, was documented as completed on 11/1/21. Resident #119 was assessed as being able to make themself understood and as able to understand others. Resident #119's Brief Interview for Mental Status (BIMS) summary score was a 12 out of 15 (this indicated intact/borderline cognition). Resident #119 was assessed as requiring limited assistance with bed mobility, transfers, eating, and personal hygiene. Resident #119's diagnoses included, but were not limited to: anemia, high blood pressure, thyroid disease, arthritis, and multiple sclerosis (MS). Resident #119's clinical record included the	F 759	Resident #119□s medications are being administered and documented correctly.12/3/2021 LPN #21 will receive education on correct medication administration and documentation by the Staff Development Coordinator. The Director of Nursing will ensure compliance. 12/08/2021 All LPN□s and RN□s responsible for administering and documenting medications will be in serviced on correct medication administration procedure by the Staff Development Coordinator. The Director of Nursing will ensure compliance. 12/30/2021 A 100% audit(see attached form) will be conducted by the Pharmacist and/or RN Nurse Managers of all nurses who administer medications to ensure correct medication administration and documentation. The Director of Nursing will ensure compliance.12/30/2021 Quarterly 20 % of all nurses who administer medications will be audited by the Pharmacist and/or RN Nurse Managers to ensure correct medication administration and documentation. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken, The Director of Nursing will ensure compliance.01/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 759	Continued From page 5	F 759		

following current orders:
- An order dated 4/16/19 for "SALINE 0.65% NASAL SPRAY, ADMINISTER 2 SPRAYS EACH NOSTRIL (twice a day) FOR ALLERGIES" and
- An order dated 12/14/19 for "BETASERON 0.3 MG KIT: 0.25 MG (subcutaneous injection) ONE TIME A DAY EVERY MON, WED, AND FRI FOR MS (RECONSTITUTE MED WITH 1.2 ML OF 0.54 SODIUM CHLORIDE, INJECT 1 ML)".

On 12/1/21 at 7:49 a.m., LPN #21 was observed to prepare and administer medications to Resident #119. LPN #21 did not administer a nasal spray to Resident #119. Resident #119's medication administration records (MARs) were reviewed on 12/1/21 at approximately 9:30 a.m. It was noted that LPN #21 had documented they had administered Resident #119's nasal spray. On 12/1/21 at 9:36 a.m., LPN #21 was interviewed about the documentation indicating they had administered Resident #119's nasal spray. LPN #21 confirmed they had not administered nasal spray to Resident #119. LPN #21 reviewed Resident #119's MARs and confirmed the nasal spray had been documented as being administered. LPN #21 reported they should not have documented the nasal spray had been administered. LPN #21 obtained Resident #119's nasal spray from the medication cart and reported they would administer the nasal spray now.

On 12/1/21 at 7:49 a.m., LPN #21 was observed to prepare Resident #119's Betaseron injection. LPN #21 reported they had withdrawn all the liquid from the Betaseron vial; LPN #21 stated all the liquid would be administered to the resident. Greater than 1 ml of liquid was noted in the syringe. This injectable medication was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 759	Continued From page 6	F 759		

transported to Resident #119's bedside. The injection site was exposed and LPN #21 opened an alcohol prep to cleanse the site. LPN #21 was asked to step back into the hallway. LPN #21 was asked about the correct dose of the Betaseron. After reviewing Resident #119's medication orders, LPN #21 confirmed an incorrect dose the Betaseron had been drawn up. LPN #21 adjusted the amount of medication in the syringe prior to reentering Resident #119's room and administering the Betaseron injection. LPN #21 administered the Betaseron injection without removing the vial and the vial adapter from the syringe.

On 12/1/21 at 9:45 a.m., a facility pharmacist (Pharmacist #1) was interviewed about the correct administration process for the Betaseron Injection; the facility's Director of Nursing (DON) and Infection Preventionist (IP) was present during this interview. Pharmacist #1 reported, when administering this dose of Betaseron, the syringe should contain 1 ml of the medication to give the ordered 0.25 mg dose. Pharmacist #1 also reported that the vial should be removed from the syringe prior to administering the Betaseron to decrease the chance of the medication going back into the vial instead of being administered to the resident.

The following information was found the Betaseron "Full Prescribing Information and Medication Guide" (this document had a copyright date of 1993):
- "Step 3: Preparing the Injection ... Remove any air bubbles by tapping the outside of the syringe with your fingers. Slowly push the plunger to the 1 mL mark on the syringe or to the mark that matches the amount of BETASERON prescribed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 759	Continued From page 7 ... Remove the vial adapter and the vial from the syringe by twisting the vial adapter. This will remove the vial adapter and the vial from the syringe, but will leave the needle on the syringe." - "Step 5: Injecting BETASERON ..." Step 5 detailed the cleaning of the injection site and the administration of the Betaseron. The following information was found in a facility policy/procedure titled "MEDICATION ADMINISTRATION" (this document was not dated): "TYPE OF MEDICATION ERRORS ... B. OMITTED DOSE - scheduled dose not given within the proper time limit or not at all without documentation of legitimate reason ... F. INCORRECT STRENGTH OF DOSE - mg, gram, gr., Units, ml, given p.o. or injected." [sic] The aforementioned medication errors, resulting in a medication error rate of 7.41%, was discussed with the facility's DON and IP on 12/1/21 at 4:52 p.m.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		1/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 761	Continued From page 8 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a narcotic medication (Lorazepam/Ativan) was stored in a locked permanently affixed compartment on one of 7 units, East unit. The findings included: The medication refrigerator on the East unit included a narcotic box that was not permanently affixed. This narcotic box included 3 vials of the narcotic Lorazepam (Ativan). Per the website https://www.dea.gov/drug-information/drug-scheduling "...Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are...Ativan ..." 11/30/21 12:30 p.m., the surveyor and RN (registered nurse) #2 checked the refrigerator on the East unit. RN #2 unlocked the refrigerator, pulled a locked brown metal tackle box from the	F 761	The narcotic medication Lorazepam/Ativan is stored in a locked box that is permanently affixed to the locked refrigerator on East Wing. The Pharmacist will ensure compliance. 12/02/2021 An audit (see attached forms) will be conducted on East wing by the RN Nurse Manager to ensure the narcotic Lorazepam/Ativan is stored in a locked box that is permanently affixed to the locked refrigerator on East Wing. The Director of Nursing will ensure compliance. 12/10/2021 Quarterly, the unit (East Wing) will be audited by the RN Nurse Manager to ensure the narcotic Lorazepam/Ativan is stored in a locked box that is permanently affixed to the locked refrigerator on East Wing. The Quality Assurance Coordinator and Director of Nursing will ensure compliance. 1/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 761	Continued From page 9 refrigerator, and placed it on the counter in the medication room. RN #2 identified this box as containing the narcotic Lorazepam. The label attached to this box read, Lorazepam 2mg/ml. 12/01/21 9:52 a.m., in an interview with pharmacist #1, they stated they were just inspected by the pharmacy board and was not aware the box needed to be permanently affixed. Pharmacist #1 stated they would have maintenance attach the box to the refrigerator immediately. 12/01/21 9:58 a.m., pharmacist #1 stated the narcotic box contained 3-2mg/ml vials of Lorazepam. 12/01/21 1:05 p.m., the surveyor requested from the DON (director of nursing) a copy of their policy in regards to storage of narcotics. The facility did not provide any documentation in regards to securing the narcotic box. 12/01/21 4:50 p.m., the DON (director of nursing) and QA (quality assurance) coordinator were made aware of the issue regarding the unsecured narcotic box on the East unit. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		1/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 842	Continued From page 10 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 842	Continued From page 11 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinica record for one of 37 residents in the survey sample, Residents #77. A 09/28/21 physician order for Resident #77 documented, "NO CPR." Review of Resident #77's DDNR (durable do not resuscitate) order form from the Virginia Department of Health revealed the facility staff failed to ensure the form was complete. Section 2 had been left blank. The findings included: Resident #77's clinical record included the	F 842	Resident #77□s DDNR has been completed correctly with appropriate blocks checked.12/7/2021 All staff responsible for completing DDNR forms will receive education on complete documentation required on the DDNR form by the Staff Development Coordinator. The Assistant Administrator will ensure compliance.12/30/2021 A 100 % audit (see attached forms) of all residents DDNR forms will be conducted by medical records personnel. Results of the audit will be reviewed by Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 842	Continued From page 12 diagnoses of unspecified dementia, hypertensive heart disease, and major depressive disorder. Section C (cognitive patterns) of Resident #77's admission MDS (minimum data set) assessment with an (ARD) assessment reference date of 10/04/21 was coded 1/1/3 to indicate the resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Resident #77's clinical record included a physicians order dated 09/28/21 that read, "NO CPR." Resident #77's clinical record included a DDNR order form dated 09/01/21 from the Virginia Department of Health. This form read in part: Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Box 2 had been checked Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. 12/01/21 RN (registered nurse) supervisor #1 reviewed the clinical record with the surveyor and acknowledged section 2 of the residents DDNR was not complete. 12/01/21 4:50 p.m., the DON (director of nursing) and QA (quality assurance) coordinator were notified of the incomplete DDNR form.	F 842	Administrator with appropriate action taken.12/30/2021 Quarterly 20 % of all resident DNR forms will be audited by medical records personnel to ensure all forms are completed correctly. Results of the audit will be reviewed by Assistant Administrator with appropriate action taken.01/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 842	Continued From page 13 No further information was provided to the survey team regarding the incomplete DDNR prior to the exit conference.	F 842		