STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495191		C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAND COUNTY NURSING & REHABILITATION CENTER	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(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 11/8/21 through 11/12/21. 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 was conducted 11/08/21 through 11/12/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 57 certified bed facility was 46 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 4 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		12/17/21

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

Electronically Signed — 12/10/2021

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and the and facility document review, the facility staff failed to ensure eleven (11) of 47 residents were provided the opportunity to to vote: Resident #1, Resident #2, Resident #10, Resident #18, Resident #21, Resident #24, Resident #36, Resident #37, Resident #38, Resident #43, and Resident #48. The findings include: The following information was found as part of the facility's Operational Policy Manual: "Activity	F 550	1. Identified residents were notified of the plan put into place to prevent recurrence since the voting time has closed for this election. 2. Residents registered to vote have potential to be affected by the deficient practice. Interviewed registered voters and no other residents were identified as being affected. 3. Activities Director educated to ensure	

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F 550	Continued From page 2 Programs ... Intellectual activities are encouraged and are designed to stimulate the resident's mind. Intellectual activities include participation in discussion groups, clubs, and committees; voting; book reviews; and music appreciation." On the afternoon of 11/10/21, a group interview with five (5) residents was completed. During this interview, it was reported that residents at the facility were not able to vote in the November 2021 elections. The group reported the absentee ballots were not obtained and the van was not available for residents to go to the polling place on Election Day. On 11/10/21 at 3:20 p.m., the Administrator was asked about resident's voting. The Administrator reported they thought the residents voted on Election Day using the van. The Activities Director (AD) was interviewed about resident voting on 11/10/21 at 3:32 p.m. The AD provided a list of 11 resident names who wanted to vote via absentee ballot. The AD reported they had missed the deadline to obtain the absentee ballots. The AD reported that two (2) residents (Resident #18 and Resident #43) wanted to vote in-person on Election Day but the polls had closed prior to the AD being able to use the transport van to take the two (2) residents to vote. On 11/10/21 at 3:41 p.m., the facility's Administrator, Director of Nursing (DON), and Chief Nursing Officer (CNO) confirmed the aforementioned residents had been unable to vote for the November 2021 election.	F 550	all residents have the opportunity to vote and provided with literature from the Virginia Department of Elections regarding early/absentee ballot voting process and timelines. Education completed and literature provided on 12/2/2021. 4. Voting process to be reviewed with residents annually and Activities will report to the CAO date of absentee ballot submission with a list of residents wishing to vote to ensure all residents have the opportunity to vote. 5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON have ultimate responsibility for the implementation of this plan.	

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F 755	Continued From page 3	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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 by: Based on staff interviews, clinical record review, and facility document review, the facility staff failed to obtain physician ordered medications for	F 755	1. Resident #25 was assessed immediately by the DON with no negative findings. Resident #45 was immediately	12/17/21

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F 755	Continued From page 4 2 of 20 residents in the survey sample, Resident #25 and #45. The findings included: 1. Resident #25's diagnosis list indicated diagnosis, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Anxiety Disorder, Cognitive Communication Deficit, Essential Hypertension, and Hypothyroidism. The most recent significant change MDS (minimum data set) with an ARD (assessment reference date) of 9/29/21 coded the resident as being moderately impaired in cognitive skills for daily decision making with short term and long term memory problems. Resident #25's current physician's orders included an active order dated 2/10/21 for Ativan tablet 0.5 mg, give 0.25 mg by mouth at bedtime related to anxiety disorder. A review of the resident's October 2021 MAR (medication administration record) revealed Ativan was not administered as ordered on 10/15/21, 10/16/21, 10/17/21, and 10/18/21. According to Resident #25's nursing progress notes, Ativan was not administered for the following documented reasons: 10/15/21 11:20 pm - "Medication unavailable. Awaiting pharmacy. MD aware" 10/16/21 10:49 pm - "Medication unavailable. Awaiting pharmacy. MD aware" 10/17/21 10:20 pm - "Medication unavailable. Awaiting pharmacy. MD aware" 10/18/21 9:55 pm - "On hold. NP (nurse practitioner) aware. RP (responsible party)	F 755	assessed for pain by Unit Manager and it was determined no pain medication was needed at that time. Upon discovery, Unit Manager contacted pharmacy for delivery and verbally reminded nurses on duty of ensuring medications are available and process of accessing STAT box medications. 2. Current residents have potential to be affected by this deficient practice. Checked availability of current ordered medications on 11/15/2021. No other residents were identified as being affected. 3. Nursing staff to be educated by the DON 12/11/2021 on accessing STAT box when medications are not available. Nurses also educated to contact pharmacy when expected medications do not arrive timely and notifying the physician for further instruction/orders. 4. DON or designee to monitor for availability of medications 5 x weekly. If medications are found to be unavailable, DON or designee to ensure STAT BOX was accessed or pharmacy/physician contacted for resolution. 5. Results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON have ultimate	

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F 755	Continued From page 5 notified" The DON (director of nursing) provided physician's orders to hold the 2100 (9:00 pm) dose of Ativan for 10/15/21, 10/16/21, 10/17/21, and 10/18/21. On 11/12/21 at 11:29 am, the pharmacy manager with the facility's contract pharmacy was interviewed concerning Resident #25's Ativan unavailability from 10/15/21 through 10/18/21. The pharmacy manager stated a 14 day supply of Ativan was dispensed on 9/30/21 for Resident #25. A refill request was sent in to the pharmacy on 10/10/21; however, the pharmacy was unable to fill the request due to a pharmacy billing error made on 9/30/21. The facility sent in another refill request on 10/18/21 and the Ativan supply was dispensed on 10/19/21. The pharmacy manager stated there was no record of the facility requesting removal of Ativan from the stat box or any additional communication concerning Resident #25's Ativan between 10/10/21 and 10/18/21 when the second refill request was submitted on 10/18/21. The facility policy entitled "Medication Shortages/Unavailable Medications" documented in part: 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the	F 755	responsibility for the implementation of this plan.	

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F 755	Continued From page 6 registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or 3.2.2 Use of an emergency (back-up) pharmacy The facility narcotic stat box listing was reviewed and included a supply of four (4) Lorazepam (Ativan) 0.5 mg tablets. On 11/12/21 at 4:26 pm, a meeting was held with the administrator, director of nursing, and the chief nursing officer and the concern of Resident #25 not receiving Ativan as ordered was discussed. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/12/21. 2. Resident #45's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/26/21, was completed on 11/2/21. Resident #45 was assessed as able to understand others and as able to make self understood. Resident #45's Brief Interview for Mental Status (BIMS) summary score was a 15 out of 15 (indicating intact/borderline cognition). Resident #45 was documented a being totally depended on others for bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and bathing. Resident #45's diagnoses included, but were not limited to: neurogenic bladder, thyroid disorder, quadriplegia, depression, post traumatic stress disorder, and borderline personality disorder. During an interview on the morning of 11/9/21,	F 755		

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F 755	Continued From page 7 Resident #45 reported having dental pain. Resident #45 reported the medical provider had ordered a different pain medication for them. Resident #45 stated the newly ordered pain medication had yet to arrive at the facility but stated that the facility staff were providing other interventions to address their dental pain. Resident #45's clinical record included an order for hydrocodone 5mg/acetaminophen 325mg one (1) tablet to be given as needed every twelve (12) hours, dated 11/8/21 at 11:22 a.m. This medication was not documented as being received at the facility until 11/11/21 at 1:07 a.m. Resident #45 was first documented as being provided this medication on 11/10/21 at 3:50 p.m. (the documentation did not specifically address whether or not this medication had been obtained via the facility STAT medication process). Resident #45's plan of care included the focus of "risk for pain ..." This care plan included the following interventions: (a) "administer medications as ordered" and (b) "refer to dentist as needed". On 11/10/21 at 5:02 p.m., a meeting was conducted with the facility's Administrator, Director of Nursing (DON), and Chief Nursing Officer (CNO). During this meeting, the delay in the availability of Resident #45's provider ordered pain medications was discussed. It was reported the pharmacy had not received the prescription and it had to be resent. The possibility of the medication being available at the facility using the facility's "STAT" medication process was discussed. The survey team was informed the pharmacy would have had to provide a "code" for the facility staff to access the medication via the	F 755		

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F 755	Continued From page 8 facility's "STAT" medication process. (STAT is a medical abbreviation used to indicate urgent or rushed.)	F 755		
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; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were three (3) errors in 33 opportunities for a medication error rate of 9.09%. These medication errors affected Resident #4 and #35. The findings included: 1. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Fracture of Right Femur, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus without Complications, Angina Pectoris, Unspecified Dementia without Behavioral Disturbance, and Gastro-esophageal Reflux Disease without Esophagitis. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 8/06/21 assigned the resident a BIMS (brief interview for mental status) score of 8 out of 15 in section C, Cognitive Patterns.	F 759	1. Resident #4's blood pressure was checked immediately upon discovery by LPN #1 and found to be within normal range. LPN#1 was verbally educated immediately by DON on obtaining vital signs per physician order prior to administration of medication. LPN #1 corrected physicians order immediately upon discovery to alert nurses of blood pressure entry prior to administration of resident #4's BP medication. Resident #4's physician notified of missed administration as well as administering BP medication without obtaining blood pressure on 11/10/2021 by Unit Manager with no new orders. Resident #35's physician was notified of incomplete dose of Lexapro immediately upon discovery by unit manager with no new orders. Nurses on duty were verbally reminded of following physician orders of obtaining vital signs, correct dose, and correct medications by the DON. 2. Current residents have potential to be	12/17/21

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F 759	Continued From page 9 Resident #4's current physician's orders included an order dated 8/16/21 for Culturelle capsule give 1 by mouth two times a day for gastro-intestinal health and an order dated 8/01/21 for Cardizem tablet 120 mg by mouth one time a day for hypertension hold if SBP (systolic blood pressure) is less than 120. On 11/10/21 at 8:16 am, LPN (licensed practical nurse) #1 was observed preparing and administering Resident #4's medications. LPN #1 administered a Cardizem 120 mg tablet to Resident #4. LPN #1 did not obtain a blood pressure prior to administration. At 12:03 pm, LPN #1 was interviewed and stated Resident #4 did not have a blood pressure check this morning but they would check the blood pressure now. LPN #1 provded a list of residents who had a blood pressure check that morning and Resident #4's name was not on the list. LPN #1 stated the MAR (medication administrator record) should provide a prompt for the blood pressure and stated "I'll fix that right now." During the medication pass and pour observation on 11/10/21 at 8:16 am, LPN #1did not administer administer Culturelle to Resident #4; however, LPN #1 signed Resident #4's MAR indicating Culturelle was administered on 11/10/21 at 9:00 am. At approximately 1:30 pm, LPN #1was interviewed concerning the administration of Culturelle and LPN #1 pulled a box of Culturelle from the medication cart and stated they think it was given. LPN #1 was unable to provide verification of Culturelle administration. On 11/10/21 at 5:02 pm during a meeting with the administrator, director of nursing, and the chief nursing officer, concerns were discussed about	F 759	affected by this deficient practice. DON monitored the next medication pass with no other residents being identified as being affected. 3. Ordered medication will be administered by licensed nurse per physician order. Nurses on duty will ensure vital signs are obtained per order, correct resident, correct medication, correct dose, correct route, correct time when administering medication. Nurses to be in-serviced on ensuring proper medication pass practices by DON on 12/11/2021. Medication Pass competencies to be completed with current nurses to ensure proper practice. 4. DON or designee to observe 3 med-passes weekly to ensure proper practice and that medications are administered as ordered. 5. Results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON have ultimate responsibility for the implementation of this plan.	

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F 759	Continued From page 10 Resident #4 not receiving Culturelle as ordered and Cardizem being administered prior to a blood pressure check on 11/10/21. The facility policy for medication administration entitled "General Dose Preparation and Medication Administration" which states in part: 4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 4.1 Facility staff should: 4.1.5 If necessary, obtain vital signs No further information regarding this concern was presented to the survey team prior to the exit conference on 11/12/21. 2. Resident #35's diagnosis list indicated diagnoses which included, but not limited to Osteomyelitis of Vertebra Cervical Region, Autistic Disorder, Cerebral Palsy, Major Depressive Disorder, and Type 2 Diabetes Mellitus. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/12/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. Resident #35's current physician's orders included an order dated 8/04/21 stating "Lexapro tablet 20 mg (Escitalopram Oxalate) give 40 mg by mouth one time a day for depression". On 11/10/21 at 8:40 am, LPN #1 was observed removing one Lexapro 20 mg tablet from a blister pack card and placing it in a medication cup with	F 759		

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F 759	Continued From page 11 the other oral medications, and administering the medications to Resident #35. After reviewing Resident #35's physician's orders, LPN #1 was intervewed on 11/10/21 at 1:25 pm, and asked if they administered one or two tablets of Lexapro 20 mg during medication pass. LPN #1 stated "I just don't know". LPN #1 pulled Resident #35's blister pack of Lexapro from the medication cart, the medication pack was labeled Lexapro 20 mg, give 40 mg and there was one tablet in each blister bubble. The facility policy for medication administration entitled "General Dose Preparation and Medication Administration" stated in part "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". On 11/10/21 at 5:02 pm during a meeting with the administrator, director of nursing, and the chief nursing officer, the concern of Resident #35 receiving the incorrect dosage of Lexapro was discussed. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/12/21.	F 759		