| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

POC NOT FINAL

| (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 000} | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid revisit to the abbreviated complaint survey conducted 8/24/21 through 8/26/21, was conducted 11/3/21 through 11/4/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey.<br><br>The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 6 current resident reviews (Residents #101 through #106). | {F 000} | | |
| {F 580} SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that | {F 580} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/20/2021

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.

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 580} | Continued From page 1<br>all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, clinical record review and facility document review, the facility staff failed to notify the resident's representative of missed medications per physician's orders for 3 out of 6 residents (Resident #102, Resident #104 and Resident #106) in the survey sample.<br><br>The findings included:<br><br>1. The facility staff failed to notify the Resident Representative (RR) that Resident #102 was not administered any of her medications on 10/23/21 | {F 580} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COURTLAND REHABILITATION AND HEALTHCARE CENTER** | **23020 MAIN STREET COURTLAND, VA 23837** |

| (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 580} | Continued From page 2<br>(7-3 shift). Resident #102 was admitted to the nursing facility on 09/08/21. Diagnosis for Resident #102 included but not limited to Hypertension (high blood pressure) and seizure disorder.<br><br>Resident #102's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 09/15/21 coded Resident #102's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.<br><br>During the review of Resident #102's Medication Administration Record (MAR) for October 2021 revealed the following orders:<br>-Amlodpine 5 mg tablet - give 1 tablet by mouth daily at 9:00 a.m., for high blood pressure.<br>-Losartan Potassium-HCTZ 100 mg tablet - give 1 tablet by mouth daily at 9:00 a.m., for high blood pressure.<br>-Eliquis 5 mg tablet - give 1 tablet by mouth at 9:00 a.m., for prevention of blood clot.<br>-Keppra 750 mg tablet by mouth daily at 8:00 a.m., for seizure disorder.<br>-Ipatropium-Albuterol solution 0.5-2.5 (3) mg 3 ml - give 3 ml via nebulizer at 9:00 a.m., and 2:00 p.m., to manage exacerbation of respiratory disease.<br><br>Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 (7-3 shift) for the medications mentioned as being administered.<br><br>An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON | {F 580} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 580} | Continued From page 3<br>was the nurse assigned to administer medication to Resident #102 on 10/23/21 (7-3 shift). The DON was asked if she administered Resident #102 her medications on 10/23/21, she replied, "No." When asked if she notified Resident #102's representative that the resident did not receive any of her scheduled medications, she replied, "No, I did not." The DON was asked if she should have notified Resident #102's representative that the scheduled medications on 10/23/21 (7-3 shift), were not administered, she replied, "Yes, the representative should have been notified."<br><br>2. The facility staff failed to notify the Resident Representative (RR) that Resident #104 was not administered any of her medications on 10/23/21 (7-3 shift). Resident #104 was admitted to the nursing facility on 10/07/21. Diagnosis for Resident #104 included but not limited to Anxiety disorder, Pain and constipation.<br><br>Resident #104's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 10/14/21 coded Resident #104's Brief Interview for Mental Status (BIMS) scored a 00 out of a possible score of 15 indicating severe cognitive impairment.<br><br>During the review of Resident #104's Medication Administration Record (MAR) for October 20201 revealed the following orders:<br>-Ativan 0.5 mg tablet daily at 8:00 a.m., for anxiety disorder.<br>-Calcium Carbonate 500 mg tablet daily at 8:00 a.m., for vitamin deficiency.<br>-Ferrous Sulfate 325 mg tablet daily at 8:00 a.m., for vitamin deficiency. | {F 580} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 580} | Continued From page 4<br>-Sennosides 8.6 mg tablet daily at 8:00 a.m., for constipation.<br>-Xarelto 10 mg tablet daily at 8:00 a.m., for blood clots.<br>-Ascorbic Acid 500 mg tablet at 9:00 a.m., for vitamin deficiency.<br>-Oxycodone 5 mg tablet at 9:00 a.m., and 2 p.m., for pain.<br><br>Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.<br><br>An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #104 on 10/23/21 (7-3 shift). The DON was asked if she administered Resident #104 her medications on 10/23/21, she replied, "No." When asked if she notified Resident #104's representative that the resident did not receive any of her scheduled medications, she replied, "No, I did not." The DON was asked if she should have notified Resident #104's representative that the scheduled medications on 10/23/21 (7-3 shift), were not administered, she replied, "Yes, the representative should have been notified."<br><br>3. The facility staff failed to notify the Resident Representative (RR) that Resident #106 was not administered any of his medications on 10/23/21 (7-3 shift). Resident #106 was originally admitted to the nursing facility on 08/25/21. Diagnosis for Resident #106 included but not limited to Chronic Obstructive Pulmonary Disease (COPD), Gout | {F 580} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 580} | Continued From page 5<br>and Urinary Retention.<br><br>Resident #106's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date of 10/13/21 coded Resident #106's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.<br><br>During the review of Resident #106's Medication Administration Record (MAR) for October 2021 revealed the following orders:<br>-Allopurinol 100 mg tablet - give 1 daily at 9:00 a.m., for gout.<br>-Breo Ellipta 100-25 mcg (inhaler) - give 1 puff at 9:00 a.m., for Chronic Obstructive Pulmonary Disease (COPD).<br>-Vitamin D 1000 units - give 2 tablets daily at 8:00 a.m., for supplement.<br>-Dutasteride 0.5 mg tablet daily 9:00 a.m., for Benign Prostatic Hyperplasia (BPH).<br>-Gabapentin 100 mg - give 3 tablets daily at 9:00 a.m., for gout.<br>-Octivite Adult 50+ - give 1 capsule daily for supplement.<br>-Miralax 17 gram - give 17 gram daily at 9:00 a.m., for constipation.<br>-Sodium Chloride 1 gram- give 1 tablet daily at 9:00 a.m., for supplement.<br>-Spirvia HandiHaler 18 mcg - give 2 puffs daily at 9:00 a.m., for COPD.<br>-Trospium Chloride 20 mg tablet - give daily at 9:00 a.m., for urinary incontinence.<br>-Ferrous Sulfate 325 mg tablet at 9:00 a.m., for supplement.<br><br>Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no | {F 580} | | |

POC NOT FINAL



| (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 580} | Continued From page 6<br>initials by the nurse) on 10/23/21 for the medications mentioned as being administered.<br><br>An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #102 on 10/23/21 (7-3 shift). The DON was asked if she administered Resident #106 his medications on 10/23/21, she replied, "No." When asked if she notified Resident #106's representative that the resident did not receive any of his scheduled medications, she replied, "No, I did not." The DON was asked if she should have notified Resident #106's representative that the scheduled medications on 10/23/21 (7-3 shift), were not administered, she replied, "Yes, the representative should have been notified."<br><br>A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m., no further information was provided prior to exit. | {F 580} | | |
| F 658 SS=E | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, facility document review, and clinical record review, the facility staff failed to follow professional standards | F 658 | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 7 | F 658 | | |

of nursing practices for 3 out of 6 residents (Resident #102, Resident #104 and Resident #106) in the survey sample.

The findings included:

1. The facility staff failed to follow physician orders for the administering of medication for Resident #102. Resident #102 was admitted to the nursing facility on 09/08/21. Diagnosis for Resident #102 included but not limited to Hypertension (high blood pressure) and seizure disorder.

Resident #102's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 09/15/21 coded Resident #102's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.

During the review of Resident #102's Medication Administration Record (MAR) for October 2021 revealed the following orders:
-Amlodpine 5 mg tablet - give 1 tablet by mouth daily at 9:00 a.m., for hypertension.
-Losartan Potassium-HCTZ 100 mg tablet - give 1 tablet by mouth daily at 9:00 a.m., for hypertension.
-Eliquis 5 mg tablet - give 1 tablet by mouth at 9:00 a.m., for prevention of blood clot.
-Keppra 750 mg tablet by mouth daily at 8:00 a.m., for seizure disorder.
-Ipatropium-Albuterol solution 0.5-2.5 (3) mg 3 ml - give 3 ml via nebulizer at 9:00 a.m., and 2:00 p.m., to manage exacerbation of respiratory disease.

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 | | F 658 | | |

Continued From page 8

Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.

Further review of Resident #102's clinical record revealed no negative outcomes related to the above medications not being administered.

An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #102 on 10/23/21 (7-3 shift). The DON was asked if she administered Resident #102 her morning medications on 10/23/21, she replied, "No." The DON said, she arrived at the facility on 10/22/21 at approximately 7:30 a.m., to perform her DON duties. She said the 3-11 nurse called out and we were not able to find nursing coverage, so I stayed over to cover the (3-11) shift. The DON said at 11:00 p.m., on the same day 10/22/21, the (11-7) night was a no-call-no-show, so I stayed over and cover that shift also. The DON said on 10/23/21, the 7-3 shift nurse never showed up for work so I had to stay over again. The DON stated, "At that point, I had already been at work for (24 hours)." She stated, "I did not pass medications to Resident #102 on 10/23/21 (7-3 shift) because it was not safe for me to pass medications after being in the facility for more than 24 hours straight with no relief.

A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m. When asked, "What

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______<br>B. WING ______ | R-C<br>11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COURTLAND REHABILITATION AND HEALTHCARE CENTER** | **23020 MAIN STREET**<br>**COURTLAND, VA 23837** |

| (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 9<br>is the expectation for administering medications as ordered by the physician, the DON replied, "To administer medication as ordered the physician or Nurse Practitioner."<br><br>2. The facility staff failed to follow physician orders for the administering of medication for Resident #104. Resident #104 was admitted to the nursing facility on 10/07/21. Diagnosis for Resident #104 included but not limited to Anxiety disorder, Pain and Constipation.<br><br>Resident #104's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 10/14/21 coded Resident #104's Brief Interview for Mental Status (BIMS) scored a 00 out of a possible score of 15 indicating severe cognitive impairment.<br><br>During the review of Resident #104's Medication Administration Record (MAR) for October 20201 revealed the following orders:<br>-Ativan 0.5 mg tablet daily at 8:00 a.m., for anxiety disorder.<br>-Calcium Carbonate 500 mg tablet daily at 8:00 a.m., for vitamin deficiency.<br>-Ferrous Sulfate 325 mg tablet daily at 8:00 a.m., for vitamin deficiency.<br>-Sennosides 8.6 mg tablet daily at 8:00 a.m., for constipation.<br>-Xarelto 10 mg tablet daily at 8:00 a.m., for blood clots.<br>-Ascorbic Acid 500 mg tablet at 9:00 a.m., for vitamin deficiency.<br>-Oxycodone 5 mg tablet at 9:00 a.m., and 2 p.m., for pain. | F 658 | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 10 | F 658 | | |

Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.

Further review of Resident #102's clinical record revealed no negative outcomes related to the above medications not being administered.

An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #104 on 10/23/21 (7-3 shift). The DON was asked if she
administered Resident #104 her morning medications on 10/23/21, she replied, "No."
The DON said, she arrived at the facility on 10/22/21 at approximately 7:30 a.m., to perform her DON duties. She said the 3-11 nurse called out and we were not able to find nursing coverage, so I stayed over to cover the (3-11) shift. The DON said at 11:00 p.m., on the same day 10/22/21, the (11-7) night was a no-call-no-show, so I stayed over and cover that shift also. The DON said on 10/23/21, the 7-3 shift nurse never showed up for work so I had to stay over again. The DON stated, "At that point, I had already been at work for (24 hours)." She stated, "I did not pass medications to Resident #104 on 10/23/21 (7-3 shift) because it was not safe for me to pass medications after being in the facility for more than 24 hours straight with no relief.

A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 11 | F 658 | | |

at approximately 3:00 p.m. When asked, "What is the expectation for administering medications as ordered by the physician, the DON replied, "To administer medication as ordered the physician or Nurse Practitioner."

3. The facility staff failed to follow physician orders for the administering of medication for Resident #106. Resident #106 was originally admitted to the nursing facility on 08/25/21. Diagnosis for Resident #106 included but not limited to Chronic Obstructive Pulmonary Disease (COPD), Gout and Urinary Retention.

Resident #106's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date of 10/13/21 coded Resident #106's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.

During the review of Resident #106's Medication Administration Record (MAR) for October 2021 revealed the following orders:
-Allopurinol 100 mg tablet - give 1 daily at 9:00 a.m., for gout.
-Breo Ellipta 100-25 mcg (inhaler) - give 1 puff at 9:00 a.m., for Chronic Obstructive Pulmonary Disease (COPD).
-Vitamin D 1000 units - give 2 tablets daily at 8:00 a.m., for supplement.
-Dutasteride 0.5 mg tablet daily 9:00 a.m., for Benign Prostatic Hyperplasia (BPH).
-Gabapentin 100 mg - give 3 tablets daily at 9:00 a.m., for gout.
-Octivite Adult 50+ - give 1 capsule daily at 9:00

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 12 | F 658 | | |

a.m., for supplement.
-Miralax 17 gram - give 17 gram daily at 9:00 a.m., for constipation.
-Sodium Chloride 1 gram- give 1 tablet daily at 9:00 a.m., for supplement.
-Spirvia HandiHaler 18 mcg - give 2 puffs daily at 9:00 a.m., for COPD.
-Trospium Chloride 20 mg tablet - give daily at 9:00 a.m., for urinary incontinence.
-Ferrous Sulfate 325 mg tablet at 9:00 a.m., for supplement.

Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.

Further review of Resident #106's clinical record revealed no negative outcomes related to the above medications not being administered.

An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #106 on 10/23/21 (7-3 shift). The DON was asked if she
administered Resident #106 his morning medications on 10/23/21, she replied, "No."
The DON said, she arrived at the facility on 10/22/21 at approximately 7:30 a.m., to perform her DON duties. She said the 3-11 nurse called out and we were not able to find nursing coverage, so I stayed over to cover the (3- 11) shift. The DON said at 11:00 p.m., on the same day 10/22/21, the (11-7) night was a no-call-no-show, so I stayed over and cover that shift also. The DON said on 10/23/21, the 7-3 shift nurse never showed up for work so I had to

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 13<br>stay over again. The DON stated, "At that point, I had already been at work for (24 hours)." She stated, "I did not pass medications to Resident #106 on 10/23/21 (7-3 shift) because it was not safe for me to pass medications after being in the facility for more than 24 hours straight with no relief.<br><br>A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m. When asked, "What is the expectation for administering medications as ordered by the physician, the DON replied, "To administer medication as ordered the physician or Nurse Practitioner." | F 658 | | |
| {F 760} SS=E | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure 3 of 6 residents (Resident #102, Resident #104 and Resident #106) in the survey sample were free of significant medication errors.<br><br>The findings included:<br><br>1. The facility staff failed to ensure the following significant medications (Amlodipine, Losartan Potassium, Eliquis and Keppra) were administered to Resident #102 on 10/23/21 (7-3 shift). Diagnosis for Resident #102 included but not limited to Hypertension (high blood pressure) | {F 760} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 760} | Continued From page 14<br>and seizure disorder.<br><br>Resident #102's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date of 09/15/21 coded Resident #102's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.<br><br>Resident #102's person-centered care plan with a revision date 09/23/21 documented resident at risk for complications related to High Blood Pressure and Coronary Artery Disease (CAD). The goal set for the resident by the staff is to remain free of complications. One intervention/approaches to manage goal included to give anti-hypertensive medication as ordered. The care plan included Resident #102 at risk for injuries and falls related to seizure disorder. The goal set for the resident by the staff is to remain free from falls/injuries r/t to seizures. One intervention/approaches to manage goal included to give seizure medication as ordered.<br><br>The care plan also included Resident #102 has the potential for bleeding for the use of anticoagulant medications related to CAD. The goal will remain free from discomfort or adverse reactions r/t anticoagulant use. One intervention/approaches to manage goal included to give the medications as ordered.<br><br>During the review of Resident #102's Medication Administration Record (MAR) for October 2021 revealed the following orders:<br>-Amlodpine 5 mg tablet - give 1 tablet by mouth daily at 9:00 a.m., for high blood pressure.<br>-Losartan Potassium-HCTZ 100 mg tablet - give | {F 760} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 760} | Continued From page 15 | {F 760} | | |

1 tablet by mouth daily at 9:00 a.m., for high blood pressure.
-Eliquis 5 mg tablet - give 1 tablet by mouth at 9:00 a.m., for prevention of blood clot.
-Keppra 750 mg tablet by mouth daily at 8:00 a.m., for seizure disorder.

Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.

Further review of Resident #102's clinical record revealed no negative outcomes related to the above medications not being administered.

An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #102 on 10/23/21 (7-3 shift). The DON was asked if she
administered Resident #102 the significant medications mentioned above, she replied, "No, the medications mentioned were not adminstered to Resident #102 on 10/23/21 (7-3 shift)."

A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m., no further information was provided prior to exit.

2. The facility staff failed to ensure the following significant medications (Ativan, Xarelto and Oxycodone) were administered to Resident #104 on 10/23/21 (7-3 shift).

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 760} | Continued From page 16 | {F 760} | | |

Resident #104 was admitted to the nursing facility on 10/07/21. Diagnosis for Resident #104 included but not limited to Anxiety disorder and pain. Resident #104's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date of 10/14/21 coded Resident #104's Brief Interview for Mental Status (BIMS) scored a 00 out of a possible score of 15 indicating severe cognitive impairment.

Resident #104's person-centered care plan with a revision date 10/22/21 documented resident has alteration in hematological status r/t to the use of Xarelto (blood thinner). The goal set for the resident by the staff is to remain free of complications. One intervention/approaches to manage goal included to give the medication as ordered. The care plan included the resident at risk for pain r/t left femur fracture. The goals is that the resident will not have an interruption in normal activities due to pain. One approach to manage goal is to evaluate the effectiveness of pain interventions.

The care plan also included the uses of Ativan (anti-anxiety) medication. The goal set for the resident by the staff will be free from discomfort or adverse reactions related to anti-anxiety therapy. One intervention/approaches to manage goal included to monitor the resident for safety due to the resident taking anti-anxiety medication.

During the review of Resident #104's Medication Administration Record (MAR) for October 20201 revealed the following orders:
-Ativan 0.5 mg tablet daily at 8:00 a.m., for anxiety disorder.

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 760} | Continued From page 17<br>-Xarelto 10 mg tablet daily at 8:00 a.m., for blood clots.<br>-Oxycodone 5 mg tablet at 9:00 a.m., and 2 p.m., for pain.<br><br>Review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.<br><br>Further review of Resident #104's clinical record revealed no negative outcomes related to the above medications not being administered.<br><br>An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #102 on 10/23/21 (7-3 shift). The DON was asked if she administered Resident #104 the significant medications mentioned above, she replied, "No, the medications mentioned were not adminstered to Resident #104 on 10/23/21 (7-3 shift)."<br><br>A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m., no further information was provided prior to exit.<br><br>3. The facility staff failed to ensure the following significant medications (Breo Ellipta, Spirvia and Gabapentin) were administered to Resident #106 on 10/23/21 (7-3 shift). Resident #106 was originally admitted to the nursing facility on 08/25/21. Diagnosis for Resident #106 included but not limited to Chronic Obstructive Pulmonary | {F 760} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 760} | Continued From page 18<br>Disease (COPD), Heart Failure and Gout.<br><br>Resident #106's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date of 10/13/21 coded Resident #106's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive skills for daily decision-making.<br><br>During the review of Resident #102's Medication Administration Record (MAR) for October 2021 revealed the following orders:<br>-Breo Ellipta 100-25 mcg (inhaler) - give 1 puff at 9:00 a.m., for COPD.<br>-Spirvia HandiHaler 18 mcg - give 2 puffs daily at 9:00 a.m., for COPD.<br>-Gabapentin 100 mg - give 3 tablets daily at 9:00 a.m., for gout.<br><br>Further review of the October 2021 MAR, revealed evidenced there were blank spaces (no initials by the nurse) on 10/23/21 for the medications mentioned as being administered.<br><br>Further review of Resident #106's clinical record revealed no negative outcomes related to the above medications not being administered.<br><br>An interview was conducted with the Director of Nursing (DON) and Vice President of Operations on 11/04/21 at approximately 2:42 p.m. The DON was the nurse assigned to administer medication to Resident #106 on 10/23/21 (7-3 shift). The DON was asked if she<br>administered Resident #106 the significant medications mentioned above, she replied, "No, the medications mentioned were not adminstered to Resident #106 on 10/23/21 (7-3 shift)." | {F 760} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COURTLAND REHABILITATION AND HEALTHCARE CENTER** | **23020 MAIN STREET COURTLAND, VA 23837** |

| (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 760} | Continued From page 19<br><br>A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m., no further information was provided prior to exit. | {F 760} | | |
| {F 842} SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is 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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance | {F 842} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COURTLAND REHABILITATION AND HEALTHCARE CENTER** | **23020 MAIN STREET COURTLAND, VA 23837** |

| (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 20<br>with 45 CFR 164.506;<br>(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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record | {F 842} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COURTLAND REHABILITATION AND HEALTHCARE CENTER** | **23020 MAIN STREET COURTLAND, VA 23837** |

POC NOT FINAL

| (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 21 | {F 842} | | |

for 1 of 6 residents (Resident #104) in the survey sample.

The findings included:

The facility staff failed to follow physician orders for the administration of a scheduled pain medication (Oxycodone 5 mg) for Resident #104. Resident #104 was admitted to the nursing facility on 10/07/21. Diagnosis for Resident #104 included but not limited left femur fracture.

Resident #104's Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 10/14/21 coded Resident #104's Brief Interview for Mental Status (BIMS) scored a 00 out of a possible score of 15 indicating severe cognitive impairment.

Resident #104's person-centered care plan with a revision date 10/22/21 documented resident with pain related to left femur fracture. The goals is that the resident will not have an interruption in normal activities due to pain. Some approaches to manage goal is to evaluate the effectiveness of pain interventions. Review of compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results.

During the review of Resident #104's Medication Administration Record (MAR) for October 20201 revealed the following order:
-Oxycodone 5 mg tablets - give 1 tablet three times a day at 9:00 a.m., 2:00 p.m., and 9:00 p.m., for pain.

The review of Resident #104's October 2021 MAR, revealed the nurse had signed off

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______<br>B. WING ______ | R-C<br>11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET<br>COURTLAND, VA 23837 |

| (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 22<br>Oxycodone 5 mg was administered on the following days: 10/17/21 @ 2:00 p.m., 10/18/21 @ 9:00 p.m., 10/21/21 @ 9:00 a.m., and 10/29/21 @ 2:00 p.m.<br><br>The review of Resident's #104's Medication Monitoring Control Record for October 2021 revealed Oxycodone 5 mg tablets were not administered on 10/17/21 @ 2:00 p.m., 10/18/21 @ 9:00 p.m., 10/21/21 @ 9:00 a.m., and 10/29/21 @ 2:00 p.m.<br><br>An interview was conducted with Unit Manager / License Practical Nurse (LPN) #1 on 11/04/21 at approximately 12:46 p.m. The LPN reviewed and compared the October 2021 MAR to the October 2021 Medication Monitoring Control Record for the administration of Oxycodone 5 mg tablet for Resident #104. After she compared the two documents, she said the nurse signed off on the MAR that the medication Oxycodone 5 mg tablets were administered on 10/17/21 @ 2:00 p.m., 10/18/21 @ 9:00 p.m., 10/21/21 @ 9:00 a.m., and 10/29/21 @ 2:00 p.m., but based on the Medication Monitoring Control Record, the medications were not administered on the days mentioned. When asked if Resident #104's MAR for October 2021 was correct for the administration of Oxycodone 5 mg she replied, "No, based on the fact the Medication Monitoring Control Record count is correct, then the MAR is not accurate."<br><br>On 11/04/21 at approximately 1:05 p.m., an interview was conducted with the Director of Nursing (DON). The DON reviewed and compared the October 2021 MAR to the October 2021 Medication Monitoring Control Record for the administration of Oxycodone 5 mg tablets for | {F 842} | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495296 | A. BUILDING ______ B. WING ______ | R-C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTLAND REHABILITATION AND HEALTHCARE CENTER | 23020 MAIN STREET COURTLAND, VA 23837 |

| (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 23<br>Resident #104. The DON stated, "Based on the fact that the Medication Monitoring Control Record count is correct, then the medications that were signed off on the MAR as being administered were not administered on the days and times mentioned above.<br><br>A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Vice President of Clinical Operations on 11/04/21 at approximately 3:00 p.m. When asked, "What is the expectation for administering medications as ordered by the physician, the DON replied, "To administer medication as ordered the physician or Nurse Practitioner and to sign off on the MAR after the medication is administered."<br><br>Definitions:<br>-Femur fracture is a break in the femur in your leg; also called the thigh bone (https://medlineplus.gov/druginfo/meds).<br>-Oxycodone is used to relieve moderate to severe pain (https://medlineplus.gov/druginfo/meds). | {F 842} | | |