STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	R-C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HEALTH & REHABILITATION CENTER	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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{E 000}	Initial Comments An unannounced Medicare/Medicaid third revisit to the abbreviated survey conducted 11/29/2021 through 11/30/2021 was conducted on 03/29/2022 through 03/30/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid third revisit to the abbreviated complaint survey conducted 11/29/2021 through 11/30/2021 was conducted on 03/29/2022 through 03/30/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 180 certified bed facility was 132 at the time of the survey. The survey sample consisted of 15 current resident reviews (Residents #301 through #315).	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to	{F 684}	The statements made in the following plan of correction are not an admission to	4/26/22

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

Electronically Signed | 04/19/2022

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{F 684}	Continued From page 1 follow physician orders for one of fifteen residents in the survey sample, Resident #313. Resident #313 was not administered two doses of fluticasone-salmeterol and two doses of ipratropium-albuterol as ordered by the physician for treatment of COPD (chronic obstructive pulmonary disease) and shortness of breath. The findings include: Resident #313 was admitted to the facility with diagnoses that included emphysema, COPD, acute and chronic respiratory failure with hypoxia, hypertension, benign prostatic hyperplasia, pneumonia, anxiety, neuromuscular dysfunction of bladder and COVID-19. The minimum data set (MDS) dated 2/11/22 assessed Resident #313 as cognitively intact. Resident #313's clinical record documented a physician's order dated 11/27/20 for fluticasone-salmeterol aerosol powder breath activated 250-50 micrograms/dose with instructions for one inhalation by mouth two times a day for treatment of COPD. The clinical record documented a physician's order dated 2/17/22 for ipratropium-albuterol solution 0.5-2.5 (3) milligrams/3 milliliters with instructions for one puff inhaled by mouth three times per day for shortness of breath. Resident #313's medication administration record (MAR) documented the resident was not administered scheduled doses of fluticasone-salmeterol aerosol 250-50 mcg/dose on 3/27/22 at 9:00 a.m. and 6:00 p.m., and was not administered scheduled doses of ipratropium-albuterol 0.5-2.5 mg/3 ml on 3/27/22 at 8:00 a.m. and 2:00 p.m. The missed doses	{F 684}	and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F684 Resident #313 is currently receiving medications as per MD orders. MD was notified of missed medications , no new orders. Current residents in the center have the potential to be affected. Licensed nurses, including outside agency nurses, will be educated by the DON/designee on following physician orders, the process for obtaining medications not available including notification to the provider for possible alternate treatment and activation of the back up Pharmacy. Education will include documentation in the medical record of notification to the physician, In addition, when medications are unavailable for administration, the DON/Administrator must be notified at time medications are unavailable. Any new agency nurses to	

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{F 684}	Continued From page 2 were coded on the MAR with a reference to see nursing notes. Nursing notes dated 3/27/22 at 10:44 a.m., 10:51 a.m., 3:11 p.m. and 6:24 p.m. documented concerning the medication doses not administered, "awaiting from pharmacy." There was no documentation about any attempts to acquire the medications from the pharmacy, use of the back-up pharmacy or notification to supervision and/or the provider about the missed doses. Resident #313's plan of care (revised 2/10/22) documented the resident was on continuous oxygen and had altered respiratory status and difficulty breathing due to COPD and emphysema. Interventions to maintain normal breathing and respiration rate/pattern included, "Administer medication/puffers as ordered..." On 3/29/22 at 4:08 p.m., Resident #313 was interviewed about the recently missed medications. Resident #313 stated he missed two of his breathing medications this past Sunday (3/27/22). Resident #313 stated the nurse working informed him that the medications were not in the cart. Resident #313 stated he did not know if the medications were not re-ordered in time or if the pharmacy just did not deliver them. On 3/29/22 at 4:40 p.m., the director of nursing (DON) was interviewed about Resident #313's missed medications on 3/27/22. The DON stated she talked with the pharmacy and the insurance coverage would not allow early re-ordering of the fluticasone-salmeterol and ipratropium-albuterol. The DON stated the supply ran out with the last doses administered on 3/26/22. The DON stated	{F 684}	the center and/or new nurse hires after the date of compliance will be educated on the above processes prior to working their first scheduled shift. The DON/designee will monitor the documentation for missed medications report from PCC and progress notes review daily for default notes from the EMAR to ensure medications are available and administrated as per physician orders. Results of the monitor will be presented to the QAPI Committee for review and discussion, one the committee determines the problem no longer exits the monitoring will be conducted on a random basis. Date of Compliance: 04/26/2022	

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{F 684}	Continued From page 3 the medications did not get to the facility on 3/27/22 in time so the resident missed two scheduled doses of each of the medicines. The DON stated the pharmacy did not deliver on Sunday until the evening. On 3/30/22 at 8:15 a.m., the survey team met with the administrator, DON and corporate consultant (administrative staff #3) about Resident #313's missed medications. The corporate consultant stated Resident #313's missed doses of fluticasone-salmeterol and ipratropium-albuterol did not show on their monitoring reports so the administrative staff were not previously aware the medicines were not given as ordered. The corporate consultant stated she interviewed the nurse administering medications on 3/27/22 to Resident #313 and the nurse said she looked in the other medication carts and was unable to locate the scheduled medicines for the resident. The DON stated the nurse should have notified the pharmacy that she did not have the medicines to administer, should have activated use of the back-up pharmacy, and should have notified the provider about a possible alternate treatment for the unavailable medicines. The DON stated there were no 24-hour pharmacy services available in the immediate area and their back-up pharmacy did not always provide immediate delivery of medications. These findings were reviewed with the administrator, director of nursing and corporate consultant on 3/29/22 at 4:45 p.m. and on 3/30/22 at 8:15 a.m.	{F 684}		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		4/26/22

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F 755	Continued From page 4 §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 resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration for one of fifteen residents in the survey sample, Resident #313. Resident #313 missed four	F 755	F755 Resident #313 is currently receiving medications as per MD orders. MD was notified of missed medications , no new orders.	

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F 755	Continued From page 5 doses of prescribed medications due to the facility's failure to obtain the drugs from the pharmacy in a timely manner. The findings include: Resident #313 was admitted to the facility with diagnoses that included emphysema, COPD (chronic obstructive pulmonary disease), acute and chronic respiratory failure with hypoxia, hypertension, benign prostatic hyperplasia, pneumonia, anxiety, neuromuscular dysfunction of bladder and COVID-19. The minimum data set (MDS) dated 2/11/22 assessed Resident #313 as cognitively intact. Resident #313's clinical record documented a physician's order dated 11/27/20 for fluticasone-salmeterol aerosol powder breath activated 250-50 micrograms/dose with instructions for one inhalation by mouth two times a day for treatment of COPD. The clinical record documented a physician's order dated 2/17/22 for ipratropium-albuterol solution 0.5-2.5 (3) milligrams/3 milliliters with instructions for one puff inhaled by mouth three times per day for shortness of breath. Resident #313's medication administration record (MAR) documented the resident was not administered scheduled doses of fluticasone-salmeterol aerosol 250-50 mcg/dose on 3/27/22 at 9:00 a.m. and 6:00 p.m., and was not administered scheduled doses of ipratropium-albuterol 0.5-2.5 mg/3 ml on 3/27/22 at 8:00 a.m. and 2:00 p.m. The missed doses were coded on the MAR with a reference to see nursing notes.	F 755	Current residents in the center have the potential to be affected. Licensed nurses, including outside agency nurses, will be educated by the DON/designee on following physician orders, the process for obtaining medications not available including notification to the provider for possible alternate treatment and activation of the back up Pharmacy. Education will include documentation in the medical record of notification to the physician, In addition, when medications are unavailable for administration, the DON/Administrator must be notified at time medications are unavailable. Any new agency nurses to the center and/or new nurse hires after the date of compliance will be educated on the above processes prior to working their first scheduled shift. The DON/designee will monitor the documentation for missed medications report from PCC and progress notes review daily for default notes from the EMAR to ensure medications are available and administrated as per physician orders. Results of the monitor will be presented to the QAPI Committee for review and discussion, one the committee determines the problem no longer exits the monitoring will be conducted on a random basis. Date of compliance: 04/26/2022	

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F 755	Continued From page 6	F 755		

Nursing notes dated 3/27/22 at 10:44 a.m., 10:51 a.m., 3:11 p.m. and 6:24 p.m. documented concerning the medication doses not administered, "awaiting from pharmacy." There was no documentation about any attempts to acquire the medications from the pharmacy, use of the back-up pharmacy or notification to supervision and/or the provider about the missed doses.

On 3/29/22 at 4:08 p.m., Resident #313 was interviewed about the recently missed medications. Resident #313 stated he missed two of his breathing medications this past Sunday (3/27/22). Resident #313 stated the nurse working informed him that the medications were not in the cart. Resident #313 stated he did not know if the medications were not re-ordered in time or if the pharmacy just did not deliver them.

On 3/29/22 at 4:40 p.m., the director of nursing (DON) was interviewed about Resident #313's unavailable medications on 3/27/22. The DON stated she talked with the pharmacy and the insurance coverage would not allow early re-ordering of the fluticasone-salmeterol and ipratropium-albuterol. The DON stated the supply ran out with the last doses administered on 3/26/22. The DON stated the medications did not get to the facility on 3/27/22 in time so the resident missed two scheduled doses of each of the medicines. The DON stated the pharmacy did not deliver on Sunday until the evening.

On 3/30/22 at 8:15 a.m., the survey team met with the administrator, DON and corporate consultant (administrative staff #3) about Resident #313's missed medications. The corporate consultant stated Resident #313's

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F 755	Continued From page 7	F 755		

missed doses of fluticasone-salmeterol and ipratropium-albuterol did not show on their monitoring reports so the administrative staff were not previously aware the medicines were not given as ordered. The corporate consultant stated she interviewed the nurse administering medications on 3/27/22 to Resident #313 and the nurse said she looked in the other medication carts and was unable to locate the scheduled medicines for the resident. The DON stated the nurse should have notified the pharmacy that she did not have the medicines to administer, should have activated use of the back-up pharmacy and should have notified the provider about a possible alternate treatment for the unavailable medicines. The DON stated there were no 24-hour pharmacy services available in the immediate area and their back-up pharmacy did not always provide immediate delivery of medications.

The facility's policy titled Provider Pharmacy Requirements (revised 08-2020) documented, "Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies...The provider pharmacy agrees to perform all of, but not only, the following pharmaceutical services...Providing routine and timely pharmacy service as contracted, as well as emergency pharmacy service 24 hours per day, seven days per week...Medications will be delivered by the primary pharmacy or back-up pharmacy or are available from the emergency medication kit/back-up medication supply..."

These findings were reviewed with the administrator, director of nursing and corporate consultant on 3/29/22 at 4:45 p.m. and on 3/30/22

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F 755	Continued From page 8 at 8:15 a.m.	F 755		