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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/19/22 through 4/21/22. 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 04/19/22 through 04/21/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. VA00053934 unsubstantiated with an unrelated deficient practice. VA00050521 substantiated with deficient practice. The census in this 60 certified bed facility was 52 at the time of the survey. The final survey sample consisted of 13 current Resident reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		

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

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status in either life-threatening conditions or clinical complications);
(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
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
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).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review,

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facility document review, and in the course of a complaint investigation, the facility staff failed to inform the resident representative of medication changes for 1 of 4 closed record reviews, Resident #106.

For Resident #106, the facility staff failed to notify the resident representative of medication changes including the discontinuation of Seroquel (an antipsychotic medication) and a new order for Risperdal (an antipsychotic medication).

The findings included:

Resident #106's diagnosis list indicated diagnoses, which included, but not limited to Auditory Hallucinations, Dementia with Behavioral Disturbance, Bilateral Benign Paroxysmal Vertigo, Diabetes Mellitus due to underlying condition with Diabetic Chronic Kidney Disease, Gastro-Esophageal Reflux Disease, and Hypothyroidism.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/23/20 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating Resident #106 was moderately cognitively impaired with verbal behavioral symptoms directed toward others exhibited one (1) to three (3) days during the MDS assessment period. Resident #106 was coded for active diagnoses including Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. The resident was also coded as receiving an antipsychotic medication and an antidepressant each day during the past seven (7) days and an antianxiety medication one (1) day during the past

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seven (7) days.

A review of Resident #106's closed clinical record revealed an order for Seroquel 25 mg every morning and 50 mg at bedtime was discontinued and a new order for Risperdal 0.5 mg by mouth at bedtime was started on 7/06/20 for hallucinations. The resident was seen by Geriatric Psychiatry on 7/06/20, the progress note stated in part "No significant improvement in (his/her) mental status probably due to (his/her) non-compliance with tx (treatment). Remains verbally agitated". Medication changes included to discontinue Quetiapine (generic for Seroquel) and start Risperidone (generic for Risperdal) oral solution 0.5 mg every bedtime to promote compliance. Surveyor reviewed Resident #106's clinical record and was unable to locate documentation of responsible party notification of the discontinuation of Quetiapine (Seroquel) and the new order for Risperidone (Risperdal).

On 4/21/22 at 10:37 am, surveyor met with the vice president of health and wellness (VPHW), admissions, quality assurance registered nurse (QARN), and the quality assurance licensed practical nurse (QALPN) regarding Resident #106's responsible party notification of the 7/06/20 physician orders to discontinue Seroquel and start Risperdal. The QARN acknowledged they also could not find responsible party notification of these order changes and stated if it was not documented, it was not done. Surveyor asked if the responsible party should have been notified of the changes and the QARN stated "yes absolutely".

Surveyor requested and received the facility policy entitled "Truthful Communication with

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F 580	Continued From page 4 Residents" which read in part "Policy Statement: Each resident shall be fully informed in a language he or she understands of his or her total health status, including but not limited to, his or her medical condition, a significant change in status, a need to alter his or her treatment significantly, or provide for transfer or discharge of the resident ....If a resident is incapable of making decisions or fully understanding the information communicated or the resident does not wish to participate, the resident's responsible representative shall be contacted of any decisions that have to be made. However, staff should still meet with the resident to inform him or her what is happening to them". On 4/21/22 at 11:17 am, surveyor met with the VPHW and director of nursing and discussed the concern of Resident #106's responsible party not being notified of medication changes from 7/06/20. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/21/22. This is a complaint deficiency.	F 580		
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	F 684		

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to follow physician orders for 1 of 13 residents, Resident #101.

The facility nursing staff administered the medication Finasteride with Resident #101's morning medications when it was ordered to be given at bedtime.

The findings included:

There was no completed minimum data set (MDS) assessment completed on this resident. The resident was alert and orientated to self and place.

Diagnoses included, but were not limited to chronic kidney disease and benign prostate hyperplasia (BPH).

04/20/22 8:28 a.m., the surveyor observed Licensed Practical Nurse (LPN) #2 prepare and administer Resident #101's medications to include the medication Finasteride 5 mg.

The residents clinical record included an order for Finasteride 5 mg 1 tab for BPH at bedtime date of order 04/19/22.

04/20/22 10:45 a.m., the surveyor and LPN #2 reviewed the clinical record. LPN #2 stated the order was changed yesterday and was previously given in the morning.

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F 684	Continued From page 6 Resident #101's clinical record included a progress note dated 04/18/22 12:55 p.m. that read in part "Rsd seen on round by...Changing BPH meds to q (every) HS (bedtime/hour of sleep) history of orthostasis..." 04/20/22 11:10 a.m., during a meeting with the Administrator and Director of Nursing (DON) the issue regarding Resident #101's Finasteride medication was reviewed. The DON stated the nurse should have checked the medication order. 04/20/22, the facility staff provided the survey team with a copy of their policy titled, "MEDICATION TREATMENT ADMINISTRATION." This policy read in part, "...The physicians order must be verified before the medication is administered..." No further information regarding this issue was provided to the survey team prior to exit conference.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		

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drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow up on a pharmacy recommendation for 1 of 13 Residents, Resident #37.

The facility staff failed to obtain the laboratory test thyroid stimulating hormone (TSH) as recommended by the attending physician.

The findings included:

Section C (cognitive patterns) of Resident #37's quarterly minimum data set (MDS) assessment

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with an assessment reference date (ARD) of 03/28/22 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

Diagnoses included, but were not limited to hypothyroidism and anxiety disorder.

The clinical record included a pharmacy recommendation dated 11/19/21 requesting a thyroid panel be completed.

The attending physician reviewed the pharmacy recommendation on 12/22/21 and documented "TSH on 12/27."

During the clinical record review, the surveyor was unable to find the results of this lab work.

04/20/22 1:50 p.m., the unit coordinator was asked for the results of the laboratory test.

04/20/21 2:20 p.m., the unit coordinator stated they were unable to find any results for the lab test.

Resident #37 was currently taking the thyroid medication Levothyroxine 50 mcg one time a day.

04/20/22 4:05 p.m., during an end of the day meeting with the survey team the Administrator and Director of Nursing (DON) were notified of the issue regarding Resident #37's pharmacy recommendation.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		

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medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, facility document review, and clinical record review, the facility staff failed ensure an accurate clinical record for 1 of 4 closed records, Resident #146.

For Resident #146, the facility staff failed to document the reason a prn (as needed) medication was administered or alternate methods of pain relief offered before

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administering the medication.

The findings were:

Resident #146's diagnosis list included, but was not limited to, non-traumatic intracranial hemorrhage, adult failure to thrive, benign prostatic hyperplasia, other injury of unspecified kidney, and atrial fibrillation. The quarterly minimum data set with an assessment reference date of 10/20/2021 coded the resident a 15 out of 15 for a brief interview for mental status summary score. The resident's care plan included a problem category of pain which read in part that the resident had recently been admitted to hospice care and the resident often had a difficult time differentiating between pain and discomfort related to a rash on his body. The approaches listed for this problem included, but were not limited to, giving pain medication as needed, re-evaluating pain status after administering medication for effectiveness, and offering non-pharmacological interventions for pain such as heat, ice, music, massage and/or repositioning. Resident #146's clinical record review was a closed record.

The resident's medication administration record (MAR) was reviewed on 04/20/2022. An order for morphine concentration - Schedule II solution; 100 mg/5mL (20mg/mL); Amount to Administer: 0.25ml orally, was noted with a frequency of every 2 hours as needed. Special instructions read to administer the 0.25ml sublingually every 2 hrs as needed for pain. The morphine order had a start date of 10/25/2021 with an open end date. The registered nurse (RN#1) documented she administered Resident #146 morphine on 12/07/2021 at 7:57 p.m. and 11:35 p.m. and

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again on the same shift, 12/08/2021 at 1:44 a.m. and 4:05 a.m. The nurse documented the morphine was given for "pain" but there was no documentation that described the resident's pain or his request for the medication. There was no documentation of any alternative method of pain relief offered prior to providing morphine.

RN#1 was interviewed via phone on 04/20/2022. The nurse stated she felt the resident was in pain based on his behavior and his affirmative response when asked whether he wanted pain medication. She acknowledged not documenting a description of Resident #146's behavior or conversation as well as her attempts at other things she tried to help comfort the resident. When asked why she did not document those encounters, the nurse stated she must have been busy since she normally does document those observations and/or pain medication requests.

The director of nursing (DON) was interviewed on 04/20/2022 at 10:45 a.m. She reported her expectation was that nurses would describe what actions they attempted to comfort a resident prior to administering a prn medication, then describe why a prn medication was given followed up with the effectiveness of the medication dose. The DON acknowledged RN#1 had not documented the expected information for Resident #146's prn morphine doses on 12/07/2021 and 12/08/2021. The DON provided evidence of staff nurses' education regarding documenting prn medications dated 12/14/2021 titled, "PRN documentation." The DON stated the education started on 12/14/2021 and continued on subsequent dates in order to educate all facility nurses.

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F 842	Continued From page 13 No further information was provided prior to the exit conference.	F 842		