PRINTED: 07/14/2022 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 150	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG	R-C	
		495046	B. WING_		06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOO	D HEALTH AND REHAB	CENTER		1613 OAKWOOD STREET BEDFORD, VA 24523		
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROPROPER DEFICIENCY)			
{E 000}	Initial Comments		{E 0	00}		
{F 000}	INITIAL COMMENTS		{F 0	00}		
{F 658} SS=D	standard survey conditions of the services provided as outlined by the commust- (i) Meet professional standards thirteen residents in this recovery the facility document review, the facility staff professional standards thirteen residents conditions.	ected deficiencies are eport. I certified bed facility was 73 ey. The survey sample at Resident reviews. et Professional Standards ii) The hensive Care Plans or arranged by the facility, aprehensive care plan, I tandards of quality. I is not met as evidenced The erview, staff interview, and clinical record failed to follow of practice for one of e survey sample. Nurses a for Resident #101 as a medications were not	{F 6	F658/12VAC5-371-220 (A)(H) Services Provided Meet Profestandards This Plan of Correct respectfully submitted as evicalleged compliance. This subsist neither an admission the deficiencies existed nor that agree with them. It is an affithe corrections to the areas of have been made and the facic compliance with the participarequirements.	essional tion is dence of mission we rmation ited lity is in	
	Resident #101 was ad	mitted to the facility with				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID: HIAI12

Facility ID: VA0027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495046	B. WING_		I .	-C 29/2022
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 658}	syndrome, chronic/se The minimum data se assessed Resident # Resident #101's clinic physician's order date (50 micrograms per s nostrils each day for o documented a physic Deep Sea 0.65% nas one spray in both nos nasal congestion. Th physician's order date 0.75% cream topically day for rosacea. Resident #101's medi (MAR) for June 2022 spray and Deep Sea administered on 6/22/ 6/27/22. The MAR do and Deep Sea spray a and 6/26/22 as ordere 6/22/22, 6/23/22, 6/24 documented the flutic spray were on order fl available for administr The resident's MAR d metronidazole 0.75% administered on 6/22/ 6/27/22 and 6/28/22. metronidazole cream on 6/25/22 and 6/26/2 6/22/22, 6/23/22, 6/24 6/22/22, 6/23/22, 6/24	ed multiple sclerosis, mnia, morbid obesity, hypertension, chronic pain asonal rhinitis and rosacea. et (MDS) dated 6/16/22 101 as cognitively intact. cal record documented a ed 12/15/21 for fluticasone pray) one spray in both chronic rhinitis. The record ian's order dated 2/28/22 for al spray with instructions for trils two times per day for e record documented a ed 6/5/22 for metronidazole of to the face two times per cation administration record documented the fluticasone masal spray were not 122, 6/23/22, 6/24/22 and coumented the fluticasone as administered on 6/25/22 ed. Nursing notes dated 122 and 6/27/22 asone spray and Deep Sea from the pharmacy and not ration. ocumented the cream was not	{F 6:	1. Residents #101 was assessed by nursing and the provide was notified of the physicial orders not followed. No adverse effects were noted residents from the failure the provide care per physician orders. It is the policy of Oakwood Health and Rehald to ensure that treatment at care are provided per physician orders. All reside have the potential to be affected by this alleged deficient practice. 2. The Director of Nursing/designee performs an audit of medications and treatments administered by nursing staff since 6/20/20. Residents who missed an administration of a medication or a treatment were assessed by nursing stand the provider and reside representative was notified.	r an lito oo bo nd ents ed di yy 22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		495046	B. WING_				06/	29/2022
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		1	613 OAK\	DRESS, CITY, STATE, ZIP CODE WOOD STREET D, VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 658}	from the pharmacy are administration. The clinical record do how the fluticasone, I metronidazole cream 6/25/22 and 6/26/22 v available. On 6/28/22 at 12:25 p nurse (LPN #2) caring interviewed about una #2 stated Resident #1 metronidazole cream 6/22/22. LPN #2 state time were provided by were ordered by the fa LPN #2 stated she the availability of the nasa transition. LPN #2 state cream was ordered are not been provided by stated the metronidaz sprays were not include medicine supply. LPN were delivered today metronidazole cream #2 stated she did not sprays were signed of weekend (6/25/22, 6/2 medications were out On 6/28/22 at 3:00 p.r. interviewed about the Sea spray and the me resident stated she was resident s	cumented no explanation of Deep Sea spray and were administered on when they were not I.m., the licensed practical profession of the prof	{F 6	58}	3.	The Staff Development Educator provided education 6/29/22 to registered a licensed staff regarding providing care per physicial orders. The education included, but was not limit to, the importance of following physician orders, the importance of administering medications and treatments as ordered. The Director of Nursing/Designee will perform an audit of medication administration and treatment administration are administered, and they are documented correctly. Audits will be completed of new written orders in la 24 hours and MAR and TA audits for last 24 hours. At will be conducted daily x 5 days x 4 weeks then month for three months to ensure	nd in ined in ited ition ved, its y its laily ist R iudits ithly	

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		495046	B. WING			06/	29/2022
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		16	TREET ADDRESS, CITY, STATE, ZIP CODE 613 OAKWOOD STREET BEDFORD, VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 658}	was still out of stock. On 6/28/22 at 3:30 p.i #1) caring for Resider about the medications when not available. L medications were ord the pharmacy. LPN # Friday 6/24/22 that the metronidazole cream available. LPN #1 states Deep Sea spray and not part of the facility's inventory and were not 6/26/22 to administer. should not have signed medications were given them as not available, sprays were delivered (6/28/22) but the metronidazole cream. On 6/29/22 at 8:20 a.r (DON) was interviewed of Resident #101's nametronidazole cream. explanation of why the were listed as adminis 6/26/22 when the medications are administration Schedules prescriber orders, pha and consideration for exact time of medicatidocumented in the Medications.	m., the unit manager (LPN at #101 was interviewed as marked as administered PN #1 stated the ered and not provided by at stated she was aware on a last of the sprays and were used and not ted the fluticasone spray, metronidazole cream were as emergency medication of available on 6/25/22 or LPN #1 stated nurses doff the MAR indicating the en but should have coded LPN #1 stated the nasal and administered today onidazole cream was still m., the director of nursing d about the administration sal sprays and The DON had no enasal sprays and cream stered on 6/25/22 and dications were not available. The director of nursing deficiency and cream stered on 6/25/22 and dications were not available.	{F 6	558}	substantial compliance is achieved. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will ident any trends and/or patters a provide education and training to staff on an ongo basis. Findings will be presented to QAPI monthly for accountability. 5. Date of Compliance: 6/30/2022	ify ind ing	

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		495046	B. WING		06/29/2022	
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE			
{F 658} {F 684} SS=E	(beyond the allowable reason is also docum The Lippincott Manual edition on page 15 indice departures from stand "Failure to administriation at timely fashion or omitted doses approprompt, accurate entrecord" (1) This finding was reviet and director of nursing 6/29/22 at 10:35 a.m. (1) Nettina, Sandra M Nursing Practice. Phi Health/Lippincott Williaguality of Care CFR(s): 483.25 § 483.25 Quality of care is a further facility residents. Base assessment of a residents receive accordance with profespractice, the compreh care plan, and the resident interview, standocument review and facility staff failed to for	e interval), or is omitted, the ented" If of Nursing Practice 11th cludes in a list of common dards of nursing care, or medications properly and to report and administer or intellyFailure to make ites in a patient's medical during a meeting on Lippincott Manual of ladelphia: Wolters Kluwer ams & Wilkins, 2019. Interpolation of the comprehensive dent, the facility must ensure treatment and care in essional standards of ensive person-centered idents' choices. Is not met as evidenced on pass observation,	{F 6		mitted ance. sted It is an the nd the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495046	B. WING			06/	29/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOO	D HEALTH AND REHAB	CENTER	1613 OAKWOOD STREET BEDFORD, VA 24523				
(VA) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 684}	failed to accurately en order for one of thirted sample. For at least four days, administered fluticaso spray and metronidaz physician. Resident #106 was not medications levothyro as ordered by the phy Resident #113 missed to inaccurate order en The findings include: 1. Resident #101 was diagnoses that include hypothyroidism, insom depression, anxiety, high syndrome, chronic/sea assessed Resident #1 Resident #101's clinical physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented a physician's order date (50 micrograms per sprostrils each day for condocumented each day for condocumented each day for condocumented each	Resident #101 was not ne spray, Deep Sea nasal ole cream as ordered by the ot administered the xine, Colace and Cymbalta sician. If doses of an antibiotic due try. admitted to the facility with ed multiple sclerosis, nnia, morbid obesity, ypertension, chronic pain asonal rhinitis and rosacea.	{F 6	884}	1. The prescription medication order for resident #113 was reviewed and revised to reflect the appropriate medication, dosage, and frequency per FNP's order. Resident # 113 was assessed by nursing staff and FNP resumed antibiotic treatme extending for a total of 7. Oakwood Heath and Rehab has identified that all residents with FNP's writter orders are at risk from this alleged deficient practice. Residents #101 and #106 were assessed by nursing at the provider was notified of the physician orders not followed. No adverse effect were noted to residents from the failure to provide care purposed to the physician orders. It is the policy of Oakwood Health at Rehab to ensure that treatment and care are provided per physician order. All residents have the	d nt nd f ts m per	
	day for rosacea.				potential to be affected by		
	Resident #101's medic	cation administration record			this alleged deficient practi	ce.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY LETED			
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UARWOO	D REALTH AND REHAD	CENTER		BEDFORD, VA 24523						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE			
{F 684}	(MAR) for June 2022 spray and Deep Sea administered on 6/22/6/27/22. The resident metronidazole 0.75% administered on 6/22/6/27/22 and 6/28/22. Nursing notes dated 6 and 6/27/22 document Deep Sea spray and if from the pharmacy and administration. A nursidocumented the metroremained on order from the pharmacy and administration or der from 1/2 caring interviewed about mis stated Resident #101' metronidazole cream pharmacy but not delimasal sprays at one timp pharmacy but now we house stock items. Let the delay in the availa was due to this transit metronidazole cream but still had not been pure LPN #2 stated the menasal sprays were not emergency medicines had not notified the promissed/unavailable menasal spray and the menasal spray and t	documented the fluticasone hasal spray were not 22, 6/23/22, 6/24/22 and 2's MAR documented the cream was not 22, 6/23/22, 6/24/22, 6/23/22, 6/24/22 ted the fluticasone spray, metronidazole were on order d not available for sing note dated 6/28/22 onidazole 0.75% cream m the pharmacy. .m., the licensed practical for Resident #101 was sed medications. LPN #2 s nasal sprays and the had been ordered from the vered. LPN #2 stated the me were provided by the re ordered by the facility as PN #2 stated she thought bility of the nasal sprays ion. LPN #2 stated the was ordered and re-ordered provided by the pharmacy. tronidazole cream and the included in their supply. LPN #2 stated she ovider about the edications.	{F 6	2. The Director of Nursing/designs an audit of med treatments adn nursing staff sin Residents who administration medication or a were assessed and the provide representative. 3. The Staff Deve Educator provion 6/29/22 to licensed staff reproviding care orders. The edincluded, but we to, the importance administering and treatments.	dications are ninistered of a missed an of a treatmen by nursing er and residence are gistered regarding per physical decion was not liminance of sician order te of medication	t staff dent ed. tion and cian nited rs,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8		CONSTRUCTION		E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	ī			TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOO	D HEALTH AND REHAB	CENTER			613 OAKWOOD STREET		
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{F 684}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 medications since the end of last week. The resident stated she "got a little congested" due to the missed nasal sprays and described the congestion as "nothing bad." Resident #101 stated her "cheeks were pink" from the missed metronidazole cream but this caused her no discomfort. On 6/28/22 at 3:10 p.m., the director of nursing (DON) was interviewed about Resident #101's missed medications. The DON stated the nasal sprays were provided previously by the pharmacy but had recently been switched to house stock. The DON did not know why the metronidazole cream had not been sent by pharmacy. On 6/28/22 at 3:30 p.m., the unit manager (LPN #1) caring for Resident #101 was interviewed about the missed medications. LPN #1 stated the medications were ordered and not provided by the pharmacy. LPN #1 stated she received no communication from the pharmacy that the nasal sprays had been switched to house stock items and were no longer provided with the pharmacy deliveries. LPN #1 stated she had called the pharmacy several times about the		PREFI)		4. The Director of Nursing/Designee will perform an audit of medication administration and treatment administrati records to ensure that physician orders are follow medications and treatment are administered, and they are documented correctly. Audits will be completed da of new written orders in las 24 hours and MAR and TAR audits for last 24 hours. Au will be conducted daily x 5 days x 4 weeks then month for three months to ensure that substantial compliance achieved. Any issues identified will be addressed immediately by the Directo	ed, aily st dits	
	the next delivery but the provided. LPN #1 state Deep Sea spray and r	netronidazole cream and was told it would be on the next delivery but the cream still had not been provided. LPN #1 stated the fluticasone spray, Deep Sea spray and metronidazole cream were not part of the facility's emergency medication			of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will ident any trends and/or patters a provide education and		
ORM CMS-2567	(revised 8/2020) document	mented, "The facility must nsure that medications are needs of each cy staff shallNotify		Faci	training to staff on an ongo basis. Findings will be presented to QAPI monthly	_	eet Page 8 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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nur una anti ava dru ava atte app circo alte nur atte sho the dire can med repl This and 6/29. I facil not dep rece data On clini clini not reas adm and The	availableNotify noticipated that the drailableSuggest aliag(s) and dosage of allableThe nursing ending physician (oplicable) of the situation of the s	order product(s) is/are ursing staff of when it is rug(s) will become Iternative, comparable of drug(s) that is/are og staff shallNotify the or on-call physician when ation and explain the oted availability, and s) available. If the facility tain a response from the or on-call physician, the nurse ing supervisor and contact irector for orders and/or ow order and order for the non-available order for the administrator of during a meeting on or sevently admitted to the org diagnoses, including but tal knee replacement, thyroidism. Due to her order was no MDS (minimum oroximately 2:00 p.m. the ord eight medications were order as scheduled with or pharmacy" for the of 8:00 p.m. on 06/27/2022	{F €	584)			

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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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OAKWOO	D HEALTH AND REHAB	CENTER			BEDFORD, VA 24523		
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{F 684}	here in the (Name of house stock." She pro available in the onsite Two of the eight medi mcg, and Duloxetine available on the (Nam dispensary) Inventory medical record, she whad signed off that sh pharmacy", had accessated, "Yes, all of our nurses now have accet to do she should have One additional medication medications were not delivered on 06/28/20 administration per phy The DON presented a 06/29/2022 at 8:53 a. following: "What to do unavailable: If the paif there is a medication steps should be taken Check OTC (over the nursing station for available prescription medication is not avail onsite dispensary), pro	se medications should be consite dispensary) or as povided a list of medications are medication dispensary. It cations, Levothyroxine 50 30 mg were both listed as ne of onsite medication and the was asked if the nurse who was "waiting on so to the dispensary. She re nurses, and the agency was. If she didn't know what wasked someone." The DON reviewed the was asked if the nurse who we was "waiting on so to the dispensary. She re nurses, and the agency was what wasked someone." The didn't know what wasked someone." The object of the dispensary is a sations Docusate Sodium and the what is available or fairly new." The other five available in house and were wastable in house and were what is available or when a medication is attent is a new admission, or an unavailable the following at the avoid a delay in care: 1. In counter) medications; 2. The dispensary was a list for medications; 3. If the lable OTC or in (name of ovider or designee must be was are unavailable and a	{F 6	884			
	designee (i.e.; Directo	r of Nursing) has been					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULI IDENTIFICATION NUMBER: (X2) MULI A. BUILDI			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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OAKWOO	D HEALTH AND REHAB	CENTER			1613 OAKWOOD STREET		
					BEDFORD, VA 24523		T
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{F 684}	Continued From page	10	{F 6	84}			
	made aware so substi necessary."	itutions can be made if					
	end of the day meetin	n was discussed during an g on 06/29/2022 at a.m. with the DON and the					
	No further information exit conference on 06,	was obtained prior to the /29/2022.					
	antibiotic medication vaccordance with profe	residents in the survey					
	limited to: anemia, der prostatic hypertrophy)	oses included, but were not mentia, BPH (benign , obstructive uropathy with use, high blood pressure,					
	quarterly review dated was assessed with a c the resident had sever decision making skills. assessed as requiring	(minimum data set) was 06/03/22. The resident cognitive score 6, indicating re impairment in daily. The resident was also supervision with set up (activities of daily living).					
		rimately 7:50 AM, a cour was completed with al Nurse) #4 for Resident					
	A medication reconcilia Resident #113 at appr	ation was completed for oximately 8:30 AM.					

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	PROVIDER OR SUPPLIER	CENTER		16	STREET ADDRESS, CITY, STATE, ZIP CODE 613 OAKWOOD STREET BEDFORD, VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	The medication recon resident had a current "Keflex 500 mg (millig mouth every 8 hours of for 7 days] (Active: 06/27/22)." This orde by the (Nurse Practitic PM. The resident's current medication administra reviewed. The EMAR Keflex Capsule 500 m on 06/27/22 at 4:00 Pl June 2022 EMAR for an "X." The EMAR for "Keflex Capsule 500 n every 8 hours every 7 did not have a start daend/discontinuation daend/discontinuat	nciliation revealed the t physician's order for, grams) Give 1 tablet by every 7 days (not every day 06/27/22 Start Date: er was entered and ordered oner) on 06/27/22 at 1:33 It EMARs (electronic ation records) were R documented that the ng was administered once PM. The remainder of the the Keflex was marked with er the Keflex documented, mgGive 1 tablet by mouth r day(s) for UTI." The order late or an late. Eximately 8:45 AM, LPN #4 reding the above information. It #113. The EMAR did not Keflex to be administered. It ked to look at the ne LPN stated that she cations entered by the led for accuracy, but stated to orders went directly to the limited what the process was for late or an eximately 8:50 AM, the DON and ADON (assistant director divided what the process was for	{F 6	84}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/14/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

R-C

		495046	B. WING			06/29/2022	
	PROVIDER OR SUPPLIER DD HEALTH AND REHAB	CENTER		161	REET ADDRESS, CITY, STATE, ZIP CODE 3 OAKWOOD STREET DFORD, VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
{F 684}	and the ADON will revite orders are entered stated that when the consisted that when the consisted the pharmacy and that for the facility to do and The DON and the ADO concern with Resident medication. The DON problem (antibiotic ordinated of every day for was intended that way on ensuring medication correctly into the election and documented, "o specify the type, route strength of the medical medications must inclute drugnumber of dand/or duration of them. On 06/29/22 at 10:15 interviewed and stated it was entered incorrectly entered for three times days. On 06/29/22 at 10:30 in were made aware again with Resident #113's a being entered correctly per the interview with the state of the sta	riew for accuracy and then into the system. The DON order is entered into the oner that it goes directly to the oner that it goes directly to the oner that it goes directly to there is not really a way audit to ensure accuracy. ON were made aware of the think it and it is antibiotic. It stated, "I think I see the dered for every 7 days or 7 days), I don't think it and it is a policy was requested in orders are entered ronic record system. If titled, "Medication Orders" reders for medication, and adde orders for unde and stop date, apy" AM, the NP was if that was an error and that only and should have been as per day everyday for 7. AM the DON and ADON in of the above concerns intibiotic medication not as intended by the NP, he NP.	{F 6	84}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONS	STRUCTION	(X3) DATE COMF	SURVEY PLETED
			1,4,50,25			R	R-C
		495046	B. WING_			06/	/29/2022
	PROVIDER OR SUPPLIER DD HEALTH AND REHAB	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
{F 755} {F 755} SS=E	Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(c) §483.45 Pharmacy State The facility must providrugs and biologicals them under an agreer §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accuradispensing, and administical personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accuradispensing, and administical pharmaceutical service that assure the accuradispensing, and administration of the provision of the provision of the provision of the provision that an according to the facility. §483.45(b)(1) Provide aspects of the provision sufficient detail to ena reconciliation; and §483.45(b)(2) Establistication of the provision of the pr	redures/Pharmacist/Records (1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed er drugs if State law er the general supervision of es. A facility must provide tes (including procedures ate acquiring, receiving, nistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed the services of a licensed the services in whes a system of records of the of all controlled drugs in ble an accurate tines that drug records are in count of all controlled drugs	{F 7}	~ 1	F755/12VAC 5-371-300(A)-Pharmacy Services/Procedures/Pharmicist/Records This Plan of Correction is respectfully submitted as evidence of alleged compliance. This submission is neither an admission the deficiencies existed nor that we agree with them. It is an affirmation the corrections the areas cited have been made and the facility is in compliance with the participation requirements. Residents #101 and #106 were assessed by nursing an the provider was notified of the physician orders not followed. Residents #101 an #106 had no adverse effects from the failure to provide care per physician orders. The prescription medication order for resident #106 was reviewed and revised to reflect the appropriate medication, dosage, and	to d d	

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			R	-C	
		495046	B. WING				29/2022	
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		1613	ET ADDRESS, CITY, STATE, ZIP CODE OAKWOOD STREET FORD, VA 24523			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 755}	medications were avaitwo of thirteen resider to ensure medication thirteen residents in the Medications prescribed 106 were not provided administration as orded. An antibiotic order for error by the provider, and/or verification by missed doses of the management of the findings include: 1. Resident #101 was diagnoses that include hypothyroidism, insom depression, anxiety, hypothyroidism, insom depression, anxiety, hypothyroidism, chronic/sea The minimum data sea assessed Resident #101's clinic physician's order date (50 micrograms per sprostrils each day for order documented a physici Deep Sea 0.65% nasa one spray in both nost nasal congestion. The physician's order date 0.75% cream topically day for rosacea. Resident #101's medication.	illable for administration for hts in the sample and failed order accuracy for one of the sample. In add for Resident #101 and the pharmacy for ered by the physician. Resident #113, entered in was filled without question the pharmacy resulting in medication. Admitted to the facility with end multiple sclerosis, ania, morbid obesity, ypertension, chronic pain assonal rhinitis and rosacea. It (MDS) dated 6/16/22 and a cognitively intact. In all record documented a decent of 12/15/21 for fluticasone oray) one spray in both hronic rhinitis. The record and sorder dated 2/28/22 for all spray with instructions for the record documented a decent of 16/5/22 for metronidazole to the face two times per decent of administration record documented the fluticasone	{F 7	55}	frequency per FNP's ord is the policy of Oakwood Health and Rehab to ensithat treatment and care provided per physician of All residents have the potential to be affected this alleged deficient prase. The Director of Nursing/designee has performed an audit of medications administere nursing staff since 6/20/2 Any resident missing an administration of a medication has been assed by nursing staff and the provider. The Staff Development Educator provided education on 6/29/22 to registered licensed staff regarding process for when a medication is not available. The education included, be was not limited to, notification to provider for new orders, accessing the STAT box, using the back-to-	d sure are orders. by octice. d by 2022. essed tion and e. out		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495046	B. WING				-C 29/2022		
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE		
{F 755}	administered on 6/22/6/27/22. The resident metronidazole 0.75% administered on 6/22/6/27/22 and 6/28/22. Nursing notes dated 6 and 6/27/22 document Deep Sea spray and from the pharmacy and administration. A nursing notes the metronidazole creating interviewed about the LPN #2 stated Reside the metronidazole creating interviewed about the LPN #2 stated the nasal sprovided by the pharm by the facility as housing stated she thought the the nasal sprays was #2 stated the metronidazole creating and re-ordered and st pharmacy. LPN #2 stoream and the nasal stheir emergency medication in the control of the control of 6/28/22 at 3:10 p.r. (DON) was interviewed unavailable medication nasal sprays were propharmacy but had reconduce stock. The DO	d'22, 6/23/22, 6/24/22 and d's MAR documented the cream was not d'22, 6/23/22, 6/24/22, 6/22/22, 6/23/22, 6/24/22 ated the fluticasone spray, metronidazole were on order and not available for sing note dated 6/28/22 anidazole 0.75% cream mithe pharmacy. I.m., the licensed practical of for Resident #101 was unavailable medications. In the #101's nasal sprays and am had been ordered from not been delivered. LPN brays at one time were enacy but now were ordered the stock items. LPN #2 and delivered are delivered are delivered are delivered by the ated the metronidazole sprays were not included in cine supply. In., the director of nursing diabout Resident #101's ins. The DON stated the vided previously by the	{F 7	(55)	pharmacy if medications a unavailable from the prim pharmacy, and reporting a concerns to the nursing supervisor. 4. The Director of Nursing/designee will audithe MAR daily, 5 times we for 4 weeks to review medication availability, accurate documentation, a provider notification. Any issues identified will be addressed immediately by Director of Nursing/design and appropriate actions where taken. The Director of Nursing/designee will identicate and additional education attraining will be provided to employees on an ongoing basis. Findings will be presented to QAPI monthly for accountability. 5. Date of Compliance: 6/30/2022	it eekly and nee vill ntify s,			

A. BUILDING R-C	-C
00/25	29/2022
OAKWOOD HEALTH AND REHAB CENTER	
BEDFORD, VA 24523	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755} Continued From page 16 {F 755}	
On 6/28/22 at 3:30 p.m., the unit manager (LPN #1) caring for Resident #101 was interviewed about the unavailable medications. LPN #1 stated the medications were ordered and not provided by the pharmacy. LPN #1 stated she received no communication from the pharmacy that the nasal sprays had been switched to house stock items and were no longer provided with the pharmacy deliveries. LPN #1 stated the pharmacy deliveries. LPN #1 stated the pharmacy was not timely with deliveries. LPN #1 stated she had called the pharmacy several times about the metronidazole cream and was told it would be on the next delivery but the cream had still not been provided. LPN #1 stated the fluticasone spray, Deep Sea spray and metronidazole cream were not part of the facility's emergency medication inventory. The facility's policy titled Unavailable Medications (revised 8/2020) documented, "The facility must make every effort to ensure that medications are available to meet the needs of each residentThe pharmacy staff shallNotify nursing staff that the order product(s) is/are unavailableNotily nursing staff of when it is anticipated that the drug(s) will become availableSuggest alternative, comparable drug(s) and dosage of drug(s) that is/are availableSuggest alternative, comparable drug(s) and dosage of drug(s) that is/are available (sic) This finding was reviewed with the administrator and director of nursing during a meeting on 6/29/22 at 10:35 a.m. 2. Resident #106 was recently admitted to the facility with the following diagnoses, including but not limited to: right total knee replacement, depression, and hypothyroidism. Due to her	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405040	B. WING			R-C	
		495046	B. WING			06/	/29/2022
	D HEALTH AND REHAB	CENTER		161	REET ADDRESS, CITY, STATE, ZIP CODE 3 OAKWOOD STREET DFORD, VA 24523		
							T
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	clinical record reviews	e 17 Proximately 2:00 p.m. the ed. Documentation the ed eight medications were	{F 7	55}			
	not given as schedule on pharmacy" for the p.m. on 06/27/2022 at	d with reasoning "Waiting administration times of 8:00 nd 6:00 a.m. on 06/28/2022.					
	06/29/2022 at approxistated, "Some of those here in the (Name of those house stock." She proposed available in the onsite Two of the eight mediance, and Duloxetine available on the (Name dispensary) Inventory medical record, she what signed off that she pharmacy", had access tated, "Yes, all of our	The DON reviewed the ras asked if the nurse who e was "waiting on st to the dispensary. She nurses, and the agency ess. If she didn't know what					
	100 mg was a stock m She stated, "The nurs checked the lists to se asked for help, she is medications were not delivered on 06/28/20 administration.	fairly new." The other five available in house and were 22 by the pharmacy for	*				
	The DON presented a 06/29/2022 at 8:53 a.r following: "What to do unavailable: If the pa	n., that contained the					

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH AND REHAB CENTER XIAMMARY STATEMENT OF DEFICIENCIES BEDFORD, VA 24523	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES BEDFORD, WA 24523 PROVIDER OF MARKED PROPERLY (RACH DEFICIENCY MUST BE PRECEDED BY FULL (RACH D						R	-C
AKWOOD HEALTH AND REHAB CENTER (A4) ID PRETIX TAG (F 755) (F 75			495046	B. WING _		06/	29/2022
CALID PREPRIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE							
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) (F 755) (F	OAKWOO	D HEALTH AND REHAB	CENTER		BEDFORD, VA 24523		
if there is a medication unavailable the following steps should be taken to avoid a delay in care: 1. Check OTC (over the counter) medication list at nursing station for available medications; 2. Check (Name of onsite dispensary) list for available prescription medications; 3. If the medication is not available OTC or in (name of onsite dispensary), provider or designee must be notified that medications are unavailable and a progress note reporting that the provider or designee (i.e.; Director of Nursing) has been made aware so substitutions can be made if necessary." The above information was discussed during an end of the day meeting on 06/29/2022 at approximately 10:30 a.m. with the DON and the administrator. No further information was obtained prior to the exit conference on 06/29/2022. 3. The facility pharmacy failed to ensure interpretation of an antibiotic medication order for accuracy for Resident #113. Resident #113's diagnoses included, but were not limited to: anemia, dementia, BPH (benign prostatic hypertrophy), obstructive uropathy with chronic Foley catheter use, high blood pressure, and gout. The most recent MDS (minimum data set) was quarterly review dated 06/03/22. The resident	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring supervision with set up only for most all ADL's (activities of daily living).	{F 755}	if there is a medication steps should be taken Check OTC (over the nursing station for ava Check (Name of onsit available prescription medication is not avail onsite dispensary), protified that medication progress note reporting designee (i.e.; Director made aware so substitutes a substitute of the day meeting approximately 10:30 and administrator. No further information exit conference on 06.3. The facility pharmal interpretation of an an accuracy for Resident #113's diagnostic hypertrophy) chronic Foley catheter and gout. The most recent MDS quarterly review dated was assessed with a content of the day meeting accurately review dated was assessed as requiring skills.	n unavailable the following to avoid a delay in care: 1. counter) medication list at aliable medications; 2. e dispensary) list for medications; 3. If the lable OTC or in (name of ovider or designee must be ons are unavailable and a log that the provider or or of Nursing) has been stutions can be made if the mass discussed during an gon 06/29/2022 at a.m. with the DON and the was obtained prior to the mass obtained prior to the medication order for mentia, BPH (benign obstructive uropathy with the use, high blood pressure, the minimum data set) was 06/03/22. The resident cognitive score 6, indicating the impairment in daily. The resident was also supervision with set up	{F 75	55}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/14/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER: A. BUILDI		BUILDING			COMPLETED	
			00000 000000000000000000000000000000000			F	R-C	
		495046	B. WING			06	/29/2022	
	ROVIDER OR SUPPLIER DD HEALTH AND REHAB	CENTER		16	TREET ADDRESS, CITY, STATE, ZIP CODE 613 OAKWOOD STREET EDFORD, VA 24523			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE	
{F 755}	On 06/29/22 at approximedication pass and pLPN (Licensed Practic #113. A medication reconcili Resident #113 at approximedication reconcesident had a current 500 mg (milligrams) G8 hours every 7 days (Active: 06/27/22 Staorder was entered by 06/27/22 at 1:33 PM. The resident's current medication administrate reviewed. The EMAR mg was administered The EMAR was block remainder of the monte EMAR for the Keflex of Capsule 500 mgGive hours every 7 day(s) ft EMAR did not have a medication and did not end/discontinuation days interviewed regar. The LPN pulled the more cord up for Resident show the medication to LPN was then asked to orders. The LPN statemedications entered by the concept of the cord of the c	ximately 7:50 AM, a pour was completed with cal Nurse) #4 for Resident dation was completed for roximately 8:30 AM. ciliation revealed the to physician order for, "Keflex sive 1 tablet by mouth every (not every day for 7 days] art Date: 06/27/22)." This the (Nurse Practitioner) on EMARs (electronic tion records) were to showed that the Keflex 500 on 06/27/22 at 4:00 PM. and out with an "X" for the the of June 2022. The documented, "Keflex to 1 tablet by mouth every 8 or UTI." The order on the start date for this to thave an tate for the antibiotic. Adding the above information. The dication administration to be administered. The to look at the physician's to the practitioner and to but stated that she thought	{F 7	755}				

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495046	B. WING			000	R-C / 29/2022	
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523	1 00/	2312022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
	(director of nursing) a of nursing) were askereviewing orders entered system. The DON statem a list of the order ADON will review for a that when the order is the practitioner that it pharmacy and that the an audit. The DON are aware of the concernantibiotic medication, see the problem, (the every 7 days, instead don't think it was intended accuracy of medication system. A pharmacy policy was "Medication Managem a resident receives a redication order is every followingThe dose, redurationand are in acclinical practice, clinical manufacturer's specific On 06/29/22 at 10:15 of interviewed and stated medication and entered that it was incorrect. Thave been entered for everyday for 7 days, nevery 7 days.	ximately 8:50 AM, the DON and ADON (assistant director d what the process was for red into the electronic ated that the NP will give as and that she and the accuracy. The DON stated entered into the system by goes directly to the ere is not really a way to do and the ADON were made with Resident #113's The DON stated, "I think I antibiotic was ordered of every day for 7 days) I ded that way." A policy was by responsibility for an orders entered into the spresented titled, lent" documented, "When hew medication, the alluated for the oute of administration, greement with current all guidelines, and/or cations for use" AM, the NP was I that she entered the dit that way in error and the NP stated that it should three times per day	{F 7	755}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495046	B. WING				-C 29/2022
	PROVIDER OR SUPPLIER DD HEALTH AND REHAB	CENTER		1613 O	ET ADDRESS, CITY, STATE, ZIP CODE DAKWOOD STREET ORD, VA 24523		80.802
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
	were made aware aga with Resident #113's a being entered correctly the NP, per the NP's in No further information presented prior to the 06/29/22 at 11:00 AM. Label/Store Drugs and CFR(s): 483.45(g)(h)('\$483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the exapplicable. §483.45(h) Storage of \$483.45(h)(1) In accorrederal laws, the facility biologicals in locked contemperature controls, a personnel to have acces \$483.45(h)(2) The facil locked, permanently af storage of controlled do the Comprehensive Drugs Control Act of 1976 and abuse, except when the package drug distribution quantity stored is mining be readily detected.	ain of the above concerns antibiotic medication not ly as actually intended by interview. and/or documentation was exit conference on de Biologicals 1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the v and cautionary expiration date when Drugs and Biologicals rdance with State and ity must store all drugs and ompartments under proper and permit only authorized	{F 7		F761/VAC5-371-300(B)-Label/Store Drugs and Biologicals This Plan of Correction is respectfully submitted as evidence of alleged compliance. This submission is neither an admission the deficiencies existed nor that we agree with them. It is an affirmation the corrections the areas cited have been made and the facility is in compliance with the participation requirements. Director of Nursing has date insulin vials on unit 2, carts A and B following verification copen date. It is the policy of Oakwood Health and Rehab to ensure medications are stored, labeled, and dated. Residents receiving medications have the potential to be affected by this alleged deficient practice.	d A of f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
				7.00			F	R-C
		495046	B. WING			***	06	/29/2022
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	CENTER		161	3 OAKW	DRESS, CITY, STATE, ZIP CODE MOOD STREET , VA 24523		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	С	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 761}	Based on observation document review, the that medications (insult opened on two of four Findings were: On 06/28/2022 at app medication carts on the observed with LPN (liet The first cart contained that was opened, but contained two vials of opened and not dated the policy was regarding a traveler, but they share opened and used discarded." The facility policy "Stocontained the following original seal of a manual is initially broken, the opening, unless the manother date or regular different dating. If a viewithout a stated date of will automatically defa and the expiration date accordingly" The above information end of day meeting without sing) and the admin approximately 10:30 a	n, staff interview, and facility facility staff failed to ensure alin) were dated when medication carts observed. Troximately 3:30 p.m., two me second floor were censed practical nurse) #3. done vial of Lispro insulinated and the container of	{F 7	61}	3.	The Director of Nursing/designee has performed a walk-throug inspection of medication and medication storage a and discarded out-of-date items and has ensured medications were labeled dated correctly. A system been implemented to aud and correct the storage, labeling, dating of medications. The Staff Development Educator provided educat on 6/29/22 to registered a licensed, staff. The educa included, but was not limit to, proper labeling, dating and storage of medication per policy. The Director of Nursing/designee will perf walk-through audits of medication carts and medication storage areas of times weekly for four week until substantial compliance identified will be immediat	carts reas land has dit ion and tion ted rs as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 10	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED				
					R-C				
		495046	B. WING_		06/	29/2022			
	PROVIDER OR SUPPLIER DD HEALTH AND REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 OAKWOOD STREET BEDFORD, VA 24523					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
				corrected and further education will be provided staff regarding prevention these variances. Findings be presented to QAPI more for accountability. 5. Date of Compliance: 6/30/2022.	of will				