STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/28/2022 through 11/30/22. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 11/28/22 through 11/30/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey: (1.) VA00054108 - unsubstantiated [no deficient practice] (2.) VA00055641 - unsubstantiated [no deficient practice] (3.) VA00055297 - unsubstantiated [no deficient practice] The census in this 168 certified bed facility was 100 at the time of the survey. The survey sample consisted of 20 current Resident reviews and two closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	**F656** **Corrective Action(s):** Resident #66 comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's incontinence of bowel and bladder.	11/04/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sabrina C. Jones	Administrator	12/12/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents with incontinence of bowel and bladder may have potentially been affected. All residents with incontinence of bowel and bladder will have their comprehensive care plans reviewed and revised by the MDS Coordinators and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. **Systemic Changes:** The DON will in-service all licensed staff on developing all triggered CAA's. **Monitoring:** The MDS coordinator, ADON and/or DON are responsible for maintaining compliance. The ADON, DON and/or MDS coordinator will perform weekly care plan audits coinciding with the care plan calendar x 4 weeks then monthly x 2 to monitor for compliance. Any/all negative findings will be reported to the DON and/or /MDS coordinator for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 1/04/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 656	Continued From page 2 clinical record review, the facility failed to develop a care plan for one of 22 resident's in the survey sample. The Findings Include: Resident #66 did not have a care plan for bowel and bladder incontinence. Diagnoses for Resident #66 included; Dysphagia, chronic obstructive pulmonary disease, bowel and bladder incontinence. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/12/2022. Resident #66 was assessed with a cognitive score of 12 indicating cognitively intact. Section "G" (Activities of Daily Living) of the current MDS documented Resident #66 needs extensive assistance with one person physical assist for toilet use. Section "F" (Bladder and Bowel) of the MDS documented Resident #66 is frequently incontinent of bladder and bowel. On 11/30/22 at 8:13 AM Resident #66 was interviewed regarding incontinence and verbalized that she sometimes knows when she has to use the bathroom but a lot of times she has soiled herself and the aides will clean her up. Resident #66 was asked if the staff ask her if she needs to use the bathroom, Resident #66 did not recall if the staff asks her if she needs to use the bathroom. Resident #66's care plan was then reviewed and did not indicate a care plan had been developed for bowel and bladder incontinence.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 656	Continued From page 3 On 11/30/22 8:57 AM registered nurse (RN #2) MDS coordinator was interviewed regarding an incontinence care plan. RN #2 reviewed the care plan and agreed there was not a specific care plan for incontinence of bowel and bladder. On 11/30/22 at 1:15 PM the above information was presented to the administrator and director of nursing (DON). No other information was presented prior to exit conference on 11/30/22.	F 656		
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 staff interview, clinical record review, and facility document review, the facility staff failed to ensure an initial assessment was completed at the time of admission for one of 22 residents, Resident #98. Findings were: Resident #98 was system selected and added to the survey sample as a closed record due to her "death in facility".	F 684	**F684** **Corrective Action(s):** Resident #98 attending physician was notified that the facility staff failed to complete initial nursing assessment on one resident. The admitting nurse for resident #98 has received 1:1 education on responsibility to complete initial nursing assessment on all residents. **Identification of Deficient Practices/Corrective Action(s):** All other residents that have been admitted may have potentially been affected. The DON, ADON and/or Unit Manager will conduct a 100% audit of all residents who have been admitted within the past 7 days to identify resident at risk.	1/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 684	Continued From page 4 She was admitted to the facility with end stage renal disease, type II diabetes mellitus, atrial fibrillation, and hypertension. No MDS (minimum data set) was completed. The clinical record was reviewed on 11/29/2022 at approximately 3:00 p.m. Documentation in the clinical record was limited. There were two progress notes observed and contained the following: "10/25/2022 07:27 (a.m.) 0525 (5:25 a.m.) Resident found with no respirations and cold to touch, 0535 (a.m.) RN (registered nurse) in facility pronounced death, 0545 (a.m.) ...Hospice notified of death. DON (director of nursing) notified of death. 0555 (a.m.) RP (responsible party) notified of death and requested services of (Name of funeral home). 0557 (a.m.) Message left on on-call service for Doctor...and NP (Nurse practitioner), notifying them of death. Also written in doctor communication book. Order written to release body...." "10/25/2022 15:20 (3:20 p.m.) (Name of Resident) was admitted... on 10/24/2022,for hospice care after being discharged from (hospital) earlier in the day. She was found to be deceased by nursing staff at 0525 this morning 10/25/2022 before she was seen by any providers on our team. Death was confirmed by nursing staff." Further review of the clinical record did not provide an admission assessment completed by staff, an admission note, or any documentation of the resident's status from the time of admission until her death. The MAR (medication administration record) was reviewed and	F 684	**Systemic Change(s):** The DON and/or ADON will in service all licensed nursing staff on the procedure to complete initial assessments on all residents. The ADON or designee will review all admissions to ensure initial nursing assessment has been completed x 12 weeks. **Monitoring:** The DON, ADON and/or unit manager will be responsible for maintaining compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice x3 months. **Completion Date: 1/04/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 684	Continued From page 5 contained orders for PRN (as needed) medications only which were not administered. The TAR (treatment administration) was reviewed. Per nursing initials, Resident #98 was turned and repositioned, heels elevated, and barrier cream applied to her buttocks on the night shift, as well as the day and evening shift after she was deceased. At approximately 4:30 p.m. the unit manager/supervisor RN #1 was interviewed regarding Resident #98. She reviewed the record and stated that there should have been an admission assessment, notes etc. She stated, "I put her orders in but that was it." She reviewed the progress note, and stated, "I don't know what had happened, I don't know what to tell you." The TAR for 10/24/2022 and 10/25/2022 was discussed. She stated, "Yes, I see that, I really don't know what to tell you." A meeting was held with the DON, the administrator, and the regional staff on 11/29/2022 at 5:45 p.m. The above information was discussed. The DON stated that she see if any hospice notes were available for the resident. She was asked if the nursing staff should do admission assessments on residents admitted for hospice services ordered. She stated, "Yes." At approximately 8:20 a.m. on 11/30/2022, the DON came to the conference room. She stated that she had interviewed the nurse (licensed practical nurse #5 who had worked 7:00 a.m. to 7:00 p.m. on 10/24/2022. She stated that he remembered the resident. He had checked on her but didn't do an assessment. He thought hospice would do that. The DON stated that she had also spoken with another nurse (LPN #7)	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 684	Continued From page 6 who had worked the afternoon Resident #98 was admitted and she remembered LPN #5 transferring the resident and assessing her, but didn't know why nothing had been documented. The DON stated that she had also spoken with LPN #6 who worked 7:00 p.m. to 7:00 a.m.. The DON stated, "(LPN #6) said that she had checked on her (Resident #98) during the night but she didn't do a note." The DON stated, "I have contacted hospice and I am trying to see if they have any notes." At approximately 11:30 a.m. the DON presented documentation from the hospice services that had assessed Resident #98 on 10/24/2022. She stated, "Here are the hospice notes, that's all I have." She was asked what should have happened. She stated, "The admitting nurse should have completed an admission assessment, that would have triggered another assessment to be done eight hours after that, and then another eight hours after that. Since the initial assessment was done, the additional assessments weren't triggered." The facility policy was requested during an meeting with the DON, the administrator, and the regional staff at approximately 1:30 p.m. The policy contained the following: "The following to be completed upon admission/readmission:....evaluation for continence...weekly skin check...admission/readmission assessment...skilled nursing note...prior function and functional abilities...mini-nutrition screen...respiratory screen..." No further information was provided prior to the exit conference on 11/30/2022.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758	**F758** **Corrective Action(s):** Resident #59's attending physician was notified that resident #59 pharmacy recommendation dated 3/29/22 was not acted upon. New orders to activate as recommended and carried out. **Identification of Deficient Practices & Corrective Actions(s):** All residents may have potentially been affected. A 100% audit on all Pharmacy recommendations for the past 60 days will be reviewed to ensure all recommendations have been carried out. **Systemic Change(s):** The DON and or Designee will inservice ADON and Unit Managers on the facility policy and procedure to complete Pharmacy Recommendations. **Monitoring:** The DON and/or ADON is responsible for maintaining compliance. The DON, ADON, and Unit Managers will audit monthly pharmacy recommendations to ensure all orders have been carried out monthly x 3 months. All negative finding will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 1/04/23**	1/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 758	Continued From page 8 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure a GDR (gradual dose reduction) for one 22 residents in the survey sample, Resident #59. Findings include: Resident #59's diagnoses included but were not limited to: high blood pressure, atrial fibrillation, Vitamin D deficiency, hypothyroidism, major depressive disorder, and anxiety disorder. The resident's most recent MDS (minimum data set) was a quarterly review dated 08/28/22. The resident was assessed with a cognitive score of 15, indicating the resident was intact for daily decision making skills. The resident was assessed as requiring extensive to full assistance most all ADL's (activities of daily living). On 11/30/22 at 8:00 AM, Resident #59's clinical records were reviewed. A pharmacy recommendation dated 03/21/22 documented, "...(Name of Resident #59) received buspirone (Buspar) 10 mg (milligrams) TID (three times daily) for GAD (generalized anxiety	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 758	Continued From page 9 disorder)...Please attempt a gradual dose reduction [GDR] with the end goal of discontinuation..." The resident's physician checked the box to accept the recommendation above with the following modifications as written by prescriber: "...decrease Buspar - 10 mg in AM, 5 mg in PM, 10 mg at hs [bedtime]...signature of physician 03/29/22." The resident's current physicians' orders were reviewed and revealed an order for Buspar 10 mg three times per day (order/start date: 09/20/21); There were no other orders to indicate that the GDR had been implemented for this medication. The resident's MARs (medication administration records) were reviewed from March 2022 up to present November 2022. The resident did not receive the GDR as ordered by the physician on the pharmacy recommendation. The resident continued to receive 10 mg of Buspar three times a day, everyday for approximately 8 months after the pharmacy recommendation was signed by the physician. The resident's current care plan documented, "...is at risk for adverse effects related to psychoactive medication use: antidepressant medication, antianxiety medication...pharmacy review per routine...monitor for effectiveness...reduction in medication doses when indicated..." On 11/130/22 at approximately 9:45 AM, the administrator was made aware of the above information. The administrator stated that the physician takes care of the pharmacy	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 758	Continued From page 10 recommendations and that the DON (director of nursing) will review also. The administrator was made aware that the physician had signed the recommendation and the order was not implemented. The administrator was asked for a policy regarding pharmacy recommendations. A policy titled, "Medication Regimen Review" was presented and documented, "...The consultant pharmacist will make recommendations and observations based on information available in the resident's electronic health record...upon completion...printed copy...will be submitted to the Director of Nursing or designee, who will notify the resident's physician/prescriber for review of consideration...facility staff should ensure that the attending physician, Medical Director, and DON are provided with copies of MRRs..." On 11/30/22 at approximately 1:40 PM, the administrator, DON and corporate nurse were made aware of the above information. The facility staff did not provide a response as to why the physician signed and approved pharmacy recommendation for a GDR for the antianxiety medication (Buspar) for Resident #59 was not implemented and/or initiated. No further information and/or documentation was presented prior to the exit conference on 11/30/22.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 761	Continued From page 11 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to label opened insulin pens on one of four nursing units. Two insulin pens stored in a medication cart on Finch unit were not marked with the date opened to ensure proper storage. The findings include: On 11/28/22 at 1:25 p.m., accompanied by registered nurse unit manager (RN #1), a medication cart was inspected on Finch unit. Stored in the cart were two insulin pens. The pens (Novolog flexpen 100 units/milliliter; Lantus Solostar insulin pen 100 units/milliliter) labeled for a current resident were opened and had no date	F 761	**F761** **Corrective Action(s):** The insulin pens missing open dates were removed and discarded and a new insulin pen with the open date and placed in medication cart. **Identification of Deficient Practices & Corrective Action(s):** Any resident with order for insulin may has the potential to be affected. The DON, ADON, and/or Unit Manager will conduct a 100% review of the medication carts to ensure special expiration dates are noted on the pen/vial or product container. Any/all negative findings will be corrected at time of discovery. **Systemic Change(s):** The ADON will inservice all licensed nursing to ensure insulin pens are dated upon opening. **Monitoring:** The ADON and/or Unit Mangers is responsible for maintaining compliance. The ADON and/or unit manager will perform weekly Medication cart audits to monitor for compliance x 12. All discrepancies found in these audits will be corrected at the time of discovery. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:1/04/23**	1/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 761	Continued From page 12 opened or discard date written on the pen. On 11/28/22 at 1:26 p.m., RN #1 was interviewed about the insulin pens with no date opened. RN #1 stated insulin pens were supposed to be labeled when opened for storage on the cart and discarded according to retention recommendations. RN #1 stated she was unable to know how long the pens had been opened since the date was not marked on the pen. The facility's pharmacy policy titled Medication Storage and Administration Quick Reference Guide (undated) documented, "...Unopened insulin pens/vials must be stored in the refrigerator. Date when opened...Affix a label to the vial or pen with resident identifiers, date opened and expiration date..." This policy documented Novolog and Lantus insulin pens stored at room temperature should be discarded 28 days after opening. This finding was reviewed with the administrator and director of nursing during a meeting on 11/29/22 at 5:45 p.m.	F 761		