STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495186		C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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	E 000		
	An unannounced Emergency Preparedness survey was conducted 1/24/2023 through 1/26/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 01/24/23 through 01/26/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five (5) complaints were investigated during the survey: VA00055671-Substantiated, without deficiency, VA00053505-Substantiated, without deficiency, VA00053423-Substantiated, without deficiency, VA00050744-Substantiated, without deficiency and VA00049397-Substantiated, without deficiency. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 39 resident reviews.			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced	F 557		2/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2023

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.

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F 557	Continued From page 1 by: Based on resident interview, observations, staff interview, clinical record review, and facility document review it was determined the facility staff failed to promote dignity for one of 39 residents in the survey sample, Resident #96. The findings include: For Resident #96 (R96), the facility staff failed to maintain a urinary catheter bag in a manner to prevent the contents from being seen from the hallway. On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 11/19/2022, the resident scored eight out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was moderately impaired for making daily decisions. The assessment documented the resident having a urinary catheter. On 1/24/2023 at 2:25 p.m., an observation was made of R96 in their room. R96 was observed asleep in bed, a urinary catheter bag was observed attached to the bed frame on the right side of the bed facing the doorway. Approximately 300 ml (milliliter) of yellow urine was observed in the bag from the hallway. On 1/24/2023 at 3:12 p.m., an interview was conducted with R96, when asked about the urine being visible in the catheter bag, R96 stated that the nurses cared for the catheter and the bag and they did not know a lot about it. Observation of the urinary catheter bag revealed the bag attached to the bed frame on the right side of the	F 557	1. Resident #96 had a dignity bag placed over the collection bag on 1/25/2023. 2. All residents with indwelling catheters have the potential to be affected. This was an isolated incident. The Director of Nursing performed an audit on 100% of all current residents with urinary catheters to ensure all collection bags were covered with dignity bags. 3. An order for verifying dignity bag placement was added to the indwelling catheter order set for nurses to sign off on the treatment record every shift. Nursing staff will be educated on the updated policy and procedure. 4. Director of Nursing/ Assistant Director of Nursing/Unit manager or designee will perform weekly spot checks on dignity bags for 8 weeks and then monthly thereafter and compliance results will be reported during standard of care meetings 5. Our corrective action plan will be in place by 2/17/2023.	

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F 557	Continued From page 2 bed facing the doorway with yellow urine observed in the bag from the hallway. Additional observations on 1/24/2023 at 5:30 p.m. and 1/25/2023 at 9:28 a.m., revealed the urinary catheter bag attached to the bed frame on the right side of the bed facing the doorway with yellow urine observed in the bag from the hallway. The physician orders for R96 documented, "Indwelling catheter r/t (related to) urinary retention. Original order date: 11/07/2022." The comprehensive care plan documented in part, "Catheter: Indwelling r/t urinary retention. Foley cath (catheter) size: 16 FR (french) Balloon size: 10 cc (cubic centimeters). Effective: 11/08/2022." On 1/25/2023 at 5:10 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that urinary catheter bags should be placed below the belly and off of the floor. LPN #2 stated that the bag should have a dignity cover over it. When asked why the bag should have a dignity cover, LPN #2 stated that the purpose was to maintain privacy for the resident and protect their dignity by covering the urine. LPN #2 observed R96 in bed in their room with the urinary catheter bag attached to the bed frame on the right side of the bed facing the doorway with yellow urine visible from the hallway and stated that the bag needed to be covered. LPN #2 stated that R96's dignity was not being maintained with the urinary catheter bag visible to visitors, staff and other residents from the hallway. The facility policy, "Foley Catheter Care with Night	F 557		

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F 557	Continued From page 3 and Leg Bags" documented in part, "...8. Place urinary drainage bag cover 'dignity cover' over the urinary collection bag..." On 1/25/2023 at 6:00 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 557		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) resident assessment for one of 39 residents in the survey sample, Resident #84. The findings include: For Resident #84 (R84), the facility staff failed to code the quarterly MDS assessment with an ARD (assessment reference date) of 12/28/2022 for a urinary catheter. On the most recent MDS assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/28/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.	F 641	1. Resident #37□s MDS and supporting documentation was reviewed. A corrected MDS that included the use of an indwelling catheter was completed on 1/26/2023. 2. All residents who require indwelling catheters have the potential to be affected. An audit was conducted on 1/27/2023 by Nursing Administration on all residents utilizing indwelling caths and their MDS□s were reviewed for accuracy and no other residents affected. 3. Residents utilizing indwelling catheters will be reviewed weekly by unit managers during Standards of Care meetings with MDS coordinators in attendance.	2/17/23

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F 641	Continued From page 4 Section H0100 failed to evidence documentation of use of an indwelling catheter. The physician orders for R84 documented in part, "Indwelling catheter r/t (related to) urinary retention d/t (due to) BPH (benign prostatic hypertrophy). Original order date: 9/14/2022..." The comprehensive care plan for R84 documented in part, "Catheter: Indwelling r/t BPH with obstruction, Foley cath (catheter) size: 16 FR (french), Balloon size: 10 cc (cubic centimeters). Effective: 9/14/2022..." On 1/26/2023 at 11:11 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator. RN #1 stated that they followed the RAI (resident assessment instrument) manual as their guide when completing the MDS assessments. RN #1 stated that if residents have a indwelling catheter during the assessment period it should be coded on the MDS assessment. RN #1 reviewed the quarterly assessment with the ARD of 12/28/2022 and stated that an indwelling catheter was not coded. RN #1 stated that they would review the clinical record to determine if R84 had the catheter during that time and if it should have been coded. On 1/26/2023 at 12:14 p.m., RN #2, MDS coordinator stated that they and RN #1 had reviewed R84's quarterly assessment with the ARD of 12/28/2022 and the clinical record and determined that it should have been coded for the indwelling catheter. RN #2 stated that they were updating the assessment to reflect the catheter. According to the RAI Manual, Version 1.16, dated October 2018, section H0100 documented in the	F 641	4. Weekly audits of MDS□s for residents with indwelling catheters will be conducted by the QAPI director or designee to ensure accurate coding of catheters. Compliance results will be reported during weekly QAPI meetings for a minimum of 12 weeks. 5. Our corrective action plan will be in place by 2/17/2023.	

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F 641	Continued From page 5 steps for assessment, "1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances..." On 1/26/2023 at 1:37 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 641		
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 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	F 656		2/17/23

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F 656	Continued From page 6 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 observation, clinical record review, staff interview and facility document review it was determined that the facility staff failed to implement the comprehensive care plan for one of 39 residents, Resident #21. The findings include: For Resident #21 (R21), the facility staff failed to implement the comprehensive care plan for the use of floor mats as ordered. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 656	1. Resident # 21 had both fall mats placed on the floor per physician order and care plan and did not have any adverse effect evident by no falls and/or injury since the fall mats were ordered. 2. All residents utilizing fall mats have the potential to be affected. An audit was conducted on 1/25/2023 by nursing administration on all residents with orders and care plans for fall mats and no other residents were affected. 3. Nursing staff will perform walking	

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F 656	Continued From page 7 reference date) of 11/30/2022, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section G documented R21 being totally dependent on two or more staff for transfers and requiring extensive assistance from one staff member for toileting and personal hygiene. Section J documented R21 having one fall with no injury since the prior assessment. On 1/24/2023 at 1:33 p.m., an observation was made of R21 in their room. R21 was observed in bed with a fall mat in place on the floor to the right side of the bed. A fall mat was observed folded and placed against the wall behind the entry door to R21's room. At this time, an interview was conducted with R21. R21 stated that they were doing well and denied any recent falls. When asked about fall mats, R21 did not answer appropriately due to their level of cognition. Additional observations of R21 on 1/24/2023 at 2:22 p.m. and 3:44 p.m. revealed R21 in bed with a fall mat in place on the floor to the right side of the bed only. The fall mat remained folded and placed against the wall behind the entry door to the room. The comprehensive care plan for R21 documented in part, "Fall: Actual Related to: 7/25/22 Lowed [sic] to floor, 11/4/22 resident found sitting on floor. Effective 7/25/2022..." Under "Interventions" it documented in part, "11/4/22- Floor mats per order. Effective 11/04/2022..." The physician orders for R21 documented in part, "Falling leaf program 11/4/2022. Original order	F 656	rounds during shift changes to verify fall mat placement per orders and care plans. Nursing staff will be in-serviced on importance or following each resident□s plan of care. 4. Nursing Administration staff will conduct daily spot checks to ensure compliance and results will be reviewed during weekly Standard of Care meetings for a minimum of 12 weeks 5. Our corrective action plan will be in place by 2/17/2023.	

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F 656	Continued From page 8 date: 11/4/2022..." The orders further documented, "Floor mats to each side of the bed when in bed. Original Order date: 11/04/2022..." The fall risk assessment dated 11/4/2022 documented R21 being a high fall risk. On 1/25/2023 at 5:10 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to serve as a guide for the residents care and should be followed to provide the best care and meet the needs of the resident. LPN #2 stated that resident who required fall mats had a physicians order for them and they were documented on the care plans. LPN #2 stated that the nurse and the CNA (certified nursing assistant) caring for any resident were able to see the care plan to know if the resident used fall mats or not. LPN #2 stated that staff took the fall mats up when they got the resident out of bed and then put them back down after they put the residents back into the bed. LPN #2 was made aware of the observations on 1/24/2023 of R21 in bed with the fall mat on the floor on the right side of the bed only and the other floor mat folded and placed against the wall behind the entry door to the room. LPN #2 stated that the staff may have forgotten to put the mat back down after putting the resident back to bed and should be following the care plan and the physician orders. LPN #2 stated that if the staff were not putting both fall mats down when R21 was in bed they were not implementing the care plan. The facility policy, "Fall Management" revised 12/22/2021, documented in part, "...Implement patient focused care plan interventions as appropriate upon admission and following an	F 656		

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F 656	Continued From page 9 actual fall..." On 1/25/2023 at 6:00 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review it was determined that the facility staff failed to implement fall interventions as ordered for one of 39 residents, Resident #21. The findings include: For Resident #21 (R21), the facility staff failed to implement fall mats as ordered. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/30/2022, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating the	F 689	1. Resident # 21 had both fall mats placed on the floor per physician order and care plan and did not have any adverse effect evident by no falls and/or injury since the fall mats were ordered. 2. All residents utilizing fall mats have the potential to be affected. An audit was conducted on 1/25/2023 by nursing administration on all residents with orders and care plans for fall mats and no other residents were affected. 3. Nursing staff will perform walking rounds during shift changes to verify fall mat placement per orders and care plans. Nursing staff will be in-serviced on	2/17/23

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F 689	Continued From page 10 resident was moderately impaired for making daily decisions. Section G documented R21 being totally dependent on two or more staff for transfers and requiring extensive assistance from one staff member for toileting and personal hygiene. Section J documented R21 having one fall with no injury since the prior assessment. On 1/24/2023 at 1:33 p.m., an observation was made of R21 in their room. R21 was observed in bed with a fall mat in place on the floor to the right side of the bed. A fall mat was observed folded and placed against the wall behind the entry door to R21's room. At this time, an interview was conducted with R21. R21 stated that they were doing well and denied any recent falls. When asked about fall mats, R21 did not answer appropriately due to their level of cognition. Additional observations of R21 on 1/24/2023 at 2:22 p.m. and 3:44 p.m. revealed R21 in bed with a fall mat in place on the floor to the right side of the bed only. The fall mat remained folded and placed against the wall behind the entry door to the room. The physician orders for R21 documented in part, "Falling leaf program 11/4/2022. Original order date: 11/4/2022..." The orders further documented, "Floor mats to each side of the bed when in bed. Original Order date: 11/04/2022..." The comprehensive care plan for R21 documented in part, "Fall: Actual Related to: 7/25/22 Lowed [sic] to floor, 11/4/22 resident found sitting on floor. Effective 7/25/2022..." Under "Interventions" it documented in part, "11/4/22- Floor mats per order. Effective 11/04/2022..."	F 689	importance or following each resident□s plan of care. 4. Nursing Administration staff will conduct daily spot checks to ensure compliance and results will be reviewed during weekly Standard of Care meetings for a minimum of 12 weeks. 5. Our corrective action plan will be in place by 2/17/2023.	

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F 689	Continued From page 11 The fall risk assessment dated 11/4/2022 documented R21 being a high fall risk. On 1/25/2023 at 5:10 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that resident who required fall mats had a physicians order for them and they were documented on the care plans. LPN #2 stated that the nurse and the CNA (certified nursing assistant) caring for any resident were able to see the care plan to know if the resident used fall mats or not. LPN #2 stated that staff took the fall mats up when they got the resident out of bed and then put them back down after they put the residents back into the bed. LPN #2 was made aware of the observations on 1/24/2023 of R21 in bed with the fall mat on the floor on the right side of the bed only and the other floor mat folded and placed against the wall behind the entry door to the room. LPN #2 stated that the staff may have forgotten to put the mat back down after putting the resident back to bed and should be following the care plan and the physician orders. The facility policy, "Fall Management" revised 12/22/2021, documented in part, "To prevent, minimize or eliminate the risk and/or occurrence of falls within the facility. The goal of this policy is to reduce the severity of injury or prevent injury related falls..." On 1/25/2023 at 6:00 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing (DON) were made aware of the above concern.	F 689		

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F 689	Continued From page 12 No further information was provided prior to exit.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview	F 755	1. Resident #15 was assessed by a	2/17/23

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F 755	Continued From page 13 and facility document review it was determined that the facility staff failed to ensure that the pharmacy provided one of 39 residents with the correct dosage of medication, Resident #15. The findings include: For Resident #15 (R15), the facility staff failed to ensure that the pharmacy provided 100 mg (milligram) of Gabapentin (1) as ordered. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/27/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The physician orders for R15 documented in part, "Gabapentin 100 mg capsule, give 1 capsule (100 mg) by oral route every 12 hours. Schedule: Every day at 6:00 am; 6:00 pm; Original Order Date: 11/14/2022..." The progress notes for R15 documented in part, - "1/21/2023 6:01 a.m. Nursing. Note: During morning med pass, writer observed that gabapentin pills were incorrect dose. MD (medical doctor) order and sticker on card states 100 mg, however actual card states 300 mg. Spoke with [Name of staff member] from [Name of pharmacy] and correct dosage will be sent out stat (right away) once [Name of pharmacy] opens at 11 am. SBAR (situation, background, assessment, recommendations) initiated and VM (voicemail) left for MD [Name of physician] answering service. Will pass on to oncoming nurse..."	F 755	medical provider on 1/24/23 and was not adversely affected by receiving the incorrect dose of Gabapentin as a result of the mislabeled medication card. 2. All residents receiving medications via medication cards have the potential to be affected. 3. Omnicare immediately discontinued the use of colored plastic bubbles of medication bingo cards and changed to clear plastic to lower the chances of not being able to identify markings and or discrepancies determining color. 4. Weekly spot checks will be conducted by unit managers to ensure no colored cards were sent from the pharmacy and compliance results will be reported during weekly Standard of Care for 12 weeks. 5. Our corrective action plan will be in place by 2/17/2023.	

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F 755	Continued From page 14 - "1/24/2023 12:17 a.m. Medical...Last evening, the nurse assigned to the patient noted his Gabapentin looked different. He is supposed to receive Gabapentin 100 mg po (by mouth) bid (twice a day), however he was given Gabapentin 300 mg bid as the card of pills from the pharmacy was mislabeled. He received 7 doses of the 300 mg caps before the issue was noted. Pharmacy has corrected the dosing issue. The patient appears to have tolerated the 300 mg bid dose, however will check labs for kidney function as his weight and systolic BP (blood pressure) have been up..." - "1/25/2023 8:12 p.m. Nursing. Note: Lab results reviewed with MD (medical doctor). No new orders received..." The comprehensive care plan for R15 documented in part, "Pain: potential for r/t (related to) edema, PVD (peripheral artery disease), arterial insufficiency, diabetes and joint pain. Effective: 11/14/2022..." On 1/26/2023 at 10:34 a.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that the Gabapentin came from the pharmacy with a label on the card of pills for the resident. ASM #3 stated that the nurses used the narcotic book sheets to sign out the medication and compared the label on the medication with the eMAR (electronic medication administration record) and the narcotic sheet in the book. ASM #3 stated that the Gabapentin for R15 had come from the pharmacy mislabeled and was actually 300 mg tablets rather than the ordered 100 mg tablets. ASM #3 stated that the pharmacy label on the medication card was 100 mg however on the back of the tablets they were 300 mg. ASM	F 755		

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F 755	Continued From page 15 #3 stated that a seasoned nurse had observed the coloring of the tablets when administering them to R15 and questioned them. ASM #3 stated that upon investigation they had determined R15 had received 7 doses of the Gabapentin 300 mg. On 1/26/2023 at 2:25 p.m., an interview was conducted with OSM (other staff member) #1, pharmacy general manager/pharmacist. OSM #1 stated that they had reported the incident of mislabeling the Gabapentin and done and in depth investigation. OSM #1 stated that when they get orders in from the facility, they have a department that puts the orders in for the pharmacy to review them for appropriateness. OSM #1 stated that after the medication was deemed appropriate, the label printed and it went to the pharmacy to be filled. OSM #1 stated that for Gabapentin it went to the controlled drug department. OSM #1 stated that ideally the medication comes prepackaged with the dose with the label on the bubble back and the pharmacist double checks the dose on the bubble back prior to dispensing. OSM #1 stated that they felt that in R15's case there was a bar code scanning issue and they thought that the bottle had been scanned with the label rather than the bubble pack. OSM #1 stated that normally the label is already on the bubble pack when it gets to fulfillment and the pharmacist double checks the medication. The facility policy, "Administering Medications" revised 10/25/2022 failed to evidence guidance for pharmacy labeling of medications. On 1/26/2023 at 1:37 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2,	F 755		

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F 755	Continued From page 16 the director of executive administration and ASM #3, the director of nursing were made aware of the above concern. No further information was provided prior to exit. Reference: (1) Gabapentin Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how Gabapentin works to treat restless legs syndrome. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html	F 755		
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.	F 756		2/17/23

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F 756	Continued From page 17 §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 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 clinical record review, staff interview and facility document review it was determined that the facility staff failed to ensure that pharmacy recommendations were reviewed and	F 756	1. Resident #21□s medication dosage was changed per pharmacy recommendation on 8/23/22.	

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F 756	Continued From page 18 implemented in a timely manner for one of 39 residents, Resident #21. The findings include: For Resident #21 (R21), the facility staff failed to implement physician approved pharmacy recommendations in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/30/2022, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. A review of the monthly pharmacy medication regimen reviews for R21 documented a consultation report for R21 dated "July 13, 2022 through July 14, 2022." The report documented in part, "...Recommendation: Please consider Paroxetine (1) 10 mg (milligram) QD (every day). Rationale for Recommendation: The manufacturer recommends dosing modification in individuals with kidney disease...Physician's Response: I accept the recommendation(s) above, please implement as written..." The recommendation documented the physician's acceptance of the recommendation with their signature and the date 7/15/22. The pharmacy consultation report dated 8/17/2022 through 8/18/2022 documented in part, "...Clinically urgent recommendation: Prompt response requested. [R21]'s prescriber accepted a pharmacy recommendation in July to consider a decrease of Paxil to 10 mg QD. The MD (medical doctor) agreed on 7-15-22 but the order	F 756	2. All residents receiving medications and medication regimen reviews (MRR□s) have the potential to be affected. A complete review was conducted by nursing administration on the last 30 days of MRR□s and all orders were implemented as recommended and approved. 3. All MRR□s will be returned by the physician to the ADON to ensure processing of orders. 4. Monthly audits will be conducted by the DON utilizing the pharmacy spreadsheet of recommendations to verify order completion as indicated and a monthly compliance report will be provided to the Administrator. 5. Our corrective action plan will be in place by 2/17/2023.	

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F 756	Continued From page 19 has not yet been processed. Recommendations: Please process the accepted pharmacy recommendation and update the medical record accordingly..." The report contained a hand-written note documenting the order changed on 8/23/22 to 10 mg QD. The physician orders for R21 documented in part, "Paroxetine 10 mg tablet, give 1 tablet (10 mg) by oral route once daily. Original order date: 08/23/2022..." On 1/26/2023 at 10:34 a.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that the pharmacist reviewed the resident records offsite and then securely email them their recommendations. ASM #3 stated that they printed out the recommendations and placed them in a basket on the physician's desk for them to review and afterwards the physician would give them to the unit manager, the assistant director of nursing or the director of nursing to make any changes to the orders and scan the document in the medical record. ASM #3 stated that the recommendation for R21 to decrease the Paroxetine to 10 mg had not gotten changed after the physician approved it in July and the pharmacist had discovered it when they did the next monthly review in August. On 1/26/2023 at approximately 2:00 p.m., ASM #3 provided a medication/transcription error report dated 9/1/22 for R21 which documented in part, "...Order involved in transcription error: Paroxetine 20 mg [right pointing arrow] 10 mg...14. Other: med dose not changed...30. Other contributing factors causing confusion (state factors) did not follow through..."	F 756		

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F 756	Continued From page 20 The facility policy, "Medication therapy and regimen review (MRR)" updated December 2017 documented in part, "1. The facility shall prevent or minimize adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON)..." On 1/26/2023 at 1:37 p.m., ASM #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the above concern. No further information was provided prior to exit. Reference: (1) Paroxetine Paroxetine tablets, suspension (liquid), and extended-release (long-acting) tablets are used to treat depression, panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698032.html	F 756		
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	F 758		2/17/23

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F 758	Continued From page 21 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 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	F 758		

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F 758	Continued From page 22 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 clinical record review, staff interview and facility document review it was determined that the facility staff failed to ensure that one of 39 residents was free from unnecessary psychotropic medications, Resident #21. The findings include: For Resident #21 (R21), the facility staff failed to implement physician approved pharmacy recommendations to reduce Paroxetine (1) in a timely manner resulting in the resident receiving 38 doses of 20 mg (milligrams) between 7/16/22 until 8/22/2022 instead of 10mg. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/30/2022, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The assessment documented R21 receiving an antidepressant. A review of the monthly pharmacy medication regimen reviews for R21 documented a consultation report for R21 dated "July 13, 2022 through July 14, 2022." The report documented in part, "...Recommendation: Please consider Paroxetine 10 mg QD (every day). Rationale for Recommendation: The manufacturer recommends dosing modification in individuals with kidney disease...Physician's Response: I accept the recommendation(s) above, please	F 758	1. Resident #21□s medication dosage was changed per pharmacy recommendation on 8/23/22. 2. All residents receiving medications and medication regimen reviews (MRR□s) have the potential to be affected. A complete review was conducted by nursing administration on the last 30 days of MRR□s and all orders were implemented as recommended and approved. 3. All MRR□s will be returned by the physician to the ADON to ensure processing of orders. 4. Monthly audits will be conducted by the DON utilizing the pharmacy spreadsheet of recommendations to verify order completion as indicated and a monthly compliance report will be provided to the Administrator. 5. Our corrective action plan will be in place by 2/17/2023.	

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F 758	Continued From page 23 implement as written..." The recommendation documented the physician's acceptance of the recommendation with their signature and the date 7/15/22. The pharmacy consultation report dated 8/17/2022 through 8/18/2022 documented in part, "...Clinically urgent recommendation: Prompt response requested. [R21]'s prescriber accepted a pharmacy recommendation in July to consider a decrease of Paxil to 10 mg QD. The MD (medical doctor) agreed on 7-15-22 but the order has not yet been processed. Recommendations: Please process the accepted pharmacy recommendation and update the medical record accordingly..." The report contained a hand-written note documenting the order changed on 8/23/22 to 10 mg QD. The physician orders for R21 documented in part, "Paroxetine 10 mg tablet, give 1 tablet (10 mg) by oral route once daily. Original order date: 08/23/2022..." The eMAR (electronic medication administration record) dated July 2022 for R21 documented Paroxetine 20 mg tablet given each day at 9:00 a.m. from 7/1/2022-7/31/2022. The eMAR dated August 2022 for R21 documented Paroxetine 20 mg tablet given each day at 9:00 a.m. from 8/1/2022-8/22/2022. The eMAR further documented Paroxetine 10 mg tablet given each day at 9:00 a.m. beginning on 8/23/2022-8/31/2022. On 1/26/2023 at 10:34 a.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495186		C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

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F 758	Continued From page 24 stated that the pharmacist reviewed the resident records offsite and then securely email them their recommendations. ASM #3 stated that they printed out the recommendations and placed them in a basket on the physician's desk for them to review and afterwards the physician would give them to the unit manager, the assistant director of nursing or the director of nursing to make any changes to the orders and scan the document in the medical record. ASM #3 stated that the recommendation for R21 to decrease the Paroxetine to 10 mg had not gotten changed after the physician approved it in July and the pharmacist had discovered it when they did the next monthly review in August. On 1/26/2023 at approximately 2:00 p.m., ASM #3 provided a medication/transcription error report dated 9/1/22 for R21 which documented in part, "...Order involved in transcription error: Paroxetine 20 mg [right pointing arrow] 10 mg...14. Other: med dose not changed...30. Other contributing factors causing confusion (state factors) did not follow through..." The facility policy, "Medication therapy and regimen review (MRR)" updated December 2017 documented in part, "1. The facility shall prevent or minimize adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON)...Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments..." On 1/26/2023 at 1:37 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2,	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 25 the director of executive administration and ASM #3, the director of nursing were made aware of the above concern. No further information was provided prior to exit. Reference: (1) Paroxetine Paroxetine tablets, suspension (liquid), and extended-release (long-acting) tablets are used to treat depression, panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698032.html	F 758		