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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 04/17/23 through 04/18/23. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated during the survey: 1. VA00058489-Non-compliant with regulations-deficient practice cited at past non-compliance. 2. VA00058428-Non-compliant with regulations-deficient practice cited at past non-compliance. The census in this 190 certified bed facility was 143 at the time of the survey. The survey sample consisted of 5 current resident reviews (Residents #1 #2, #3, #5, and #9) and 4 closed record reviews (Residents #4, #6, #7, and #8).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure the highest practicable well-being for 1 of	F 684	Past noncompliance: no plan of correction required.	

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

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9 residents reviewed (Resident #6). This is past noncompliance.

The findings:

Facility staff failed to initiate emergency medical services and failed to provide cardiopulmonary resuscitation when Resident #6 was found unresponsive, cool to the touch, not breathing with no heartbeat.

Resident #6's Admission Record listed diagnoses which included but were not limited to, burns involving less than 10% of body surface, chronic kidney disease, Type 2 Diabetes Mellitus with hyperglycemia, heart failure, cocaine abuse, pulmonary hypertension, other psychoactive substance dependence, and unspecified atrial fibrillation. On the Minimum Data Set document with an assessment reference date 03/28/23, the resident scored a 10 out of 15 on the brief interview for mental status in Section C (cognitive patterns).

A facility reported incident read the resident was found unresponsive, unarousable, and cool to the touch on 4/10/23. The resident had an order for a full code. The registered nurse (RN#1) assigned to Resident #6 called the medical doctor/medical director (MD) to report the clinical resident assessment. Due to the assessment findings and resident comorbidities, the MD called the resident's time of death via phone and gave an order for postmortem care and to notify the family and funeral home.

Clinical record review revealed Resident #6's primary physician, also the facility's medical director, wrote an order for "full code - CPR" on

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03/23/23. The clinical record contained a care plan with a focus area that read the resident wished to be full code status. Interventions included, but were not limited to, CPR (cardiopulmonary resuscitation) certified staff would provide chest compressions when the residents' heart stops.

The MD was interviewed via phone on 4/18/23 at 1:52 p.m. and 2:32 p.m. The physician acknowledged receiving RN #1's call about finding Resident #6 deceased and cold and had not been seen since going to bed that night. The MD stated since the resident was cold and stiff, it was clear the resident was dead, and CPR would not have changed the outcome. The MD reported that although a full code status resident should receive CPR when found unresponsive, in this specific case based on RN#1's assessment, the physician was comfortable with CPR not being initiated. He acknowledged providing the verbal order over the telephone for staff to provide postmortem care and to send the resident to the funeral home. The clinical record contained the MD's progress note dated 04/10/23 at 3:20 a.m. which read in part, "Found dead in bed. This 56 YO man with heart [sic] failure, AF, hx of nonsustained ventricular tachycardia, and ejection fraction of 15-20% was found dead and cold in bed. He had not been seen alive for several hours. Family had been contacted and gave preference of funeral home. Resuscitative efforts in this setting would [sic] have been futile." The doctor electronically signed this progress note on 4/11/23 at 7:52 a.m.

Multiple facility staff were interviewed on 4/18/23 to include two licensed practical nurses (LPN#10 and LPN#11) and one registered nurse (RN#4) all

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who were working on the unit where Resident #6 had resided. The LPNs and RN were interviewed separately, and all acknowledged they received Code Blue training in recent days/weeks and consistently during their employment. They described the process of finding a resident unresponsive and verifying their code status in the computer. If the resident had a Full Code status, someone would call a code over the intercom in order to receive support from other staff, someone would call 911 while other staff started CPR. CPR would continue until 911 arrived. The nurses stated they would call a code and initiate CPR regardless of whether the resident was cold. LPN#10 stated there were circumstances when CPR would not be initiated such as a resident with a Do Not Resuscitate order or someone with symptoms of irreversible death for example, rigor mortis (body stiffening). When asked how staff would verify residents' code status if the computer system was down, all of the nurses reported a list was kept at the nurses' station. LPN#10 and RN#4 showed the surveyor two black binders with active residents' face sheets and code status documentation which was kept at the nurses' station.

The director of nursing (DON) attempted to call RN#1 (assigned to Resident #6) multiple times on 4/18/23 without success therefore the nurse was not interviewed. The administrative team provided their investigation documentation which included a handwritten statement from RN#1. The nurse wrote she gave Resident #6 medications at approximately 8:15 p.m. at which time the resident reported not needing anything and was watching television. The resident, with a history of normally refusing medications, did agree to take medications but refused the

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treatment to his groin/legs. The certified nursing assistant (CNA) provided fresh water. RN#1 wrote around midnight, she spoke to Resident #6 from the door asking, "you need anything, you good?" and the resident threw his hand up however, his face and head was covered with a blanket. At approximately 2:15 a.m. on 4/10/23 a CNA#2 reported to RN#1 that Resident #6 was dead. The nurse and CNA went to the resident's room. RN#1 wrote the resident was "unarousable, unresponsive, no pupil reaction, no audible heartbeat, no respirations, cool to the touch, flat on back, hands crossed (arms esp), rolled to side, noted cool backside as well." RN#1 called the physician and told him what she and the CNA had found, and she had "just checked the code status and is Full Code." RN#1 wrote the MD said, "Well time of death 0215 (2:15 a.m.), do the postmortem care, notify family, call the funeral home." RN#1 notified the responsible party (RP) and the family's choice of funeral homes. RN#1 wrote a progress note effective 4/10/23 at 2:15 a.m. which described events the same as her statement read.

CNA#2, who found Resident #6 deceased, wrote a statement about working on the West Wing for night shift on 4/09/23 (4/10/23 at midnight). The CNA was not available for interview during the survey. Her statement read the nursing assistant had a conversation with Resident #6 upon starting her shift and she put his oxygen back on which the resident would take off at times. The resident reported he was "ok and he needed rest." CNA#2 wrote when she found him, he looked as if he was "relaxed and sleeping." A second CNA's statement read she changed Resident #6's brief at approximately 12:00 a.m.

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The DON was interviewed along with the Administrator and Quality Assurance Director on 4/18/23 in the afternoon. The DON reported her expectation was the staff would verify residents' code status and progress accordingly. In Resident #6's case, according to the RN's observations there were signs of irreversible death which was explained to the MD.

The DON provided a copy of RN#1's current American Heart Association's Basic Life Support card with an issue date of 3/02/23.

The administrative team (Administrator, DON, and Quality Director) provided evidence of their investigation and QAPI Action Plan. The plan, except for monthly Code Blue Drills, was competed on 4/14/23 if not earlier. The Quality Team determined RN#1 and all staff would be educated on how to identify code status and when to implement CPR. RN#1 was suspended during the investigation. The quality plan included educating licensed nurses on when not to initiate CPR and to notify Administrator or DON of any resident death or code initiated. An audit of 100% medical records to determine code status of residents to ensure the order matches the resident's desire on the Preferred Intensity of Care. The 100% audit of medical records included resident care plans to ensure they matched the physician orders for Code status and current with Preferred Intensity of Care. A 100% audit of resident demographic books at the nurse's station to ensure all residents' code statuses were included. CNAs were educated on where to find code status orders. Interdepartmental Team (IDT) meetings will discuss any changes in code status orders. And an audit of resident deaths for the past 30 days to

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F 684	Continued From page 6 ensure code blue was initiated as ordered. There had been three (3) deaths in the last 30 days (excluding Resident #6). All three residents had a Do Not Resuscitate order. The monitoring and reporting to Quality Assurance oversight will be done "indefinitely." A surveyor reviewed other residents who had died in the facility. No concerns were identified. The DON provided a policy titled "Cardiopulmonary Resuscitation (CPR)" which read in part, "The facility will provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care, prior to the arrival of emergency medical personnel, in accordance with physician orders, such as a DNR, and the resident's advance directives." During a summary meeting on 4/18/23, the Administrator, the DON, and Quality Director were notified the issue was to be considered past non-compliance with a correction plan completed.	F 684		
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 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	F 761		

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F 761	Continued From page 7 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 staff interview, clinical record review, and facility document review, the facility staff failed to secure medications on 1 of 3 wings, West Wing. The findings included: The facility nursing staff left the nursing keys on top of the medication cart unattended, resulting in missing narcotics. 03/28/23, the facility staff reported to the Office of Licensure and Certification via a facility reported incident (FRI) that on 03/28/23 Licensed Practical Nurse (LPN) #1 left their medication keys on top of their medication cart. When LPN #1 completed a verification check of their narcotics prior to the end of their shift they noticed a total of nine (9) narcotic pain medications missing. Resident #1 missing one Hydrocodone/Acetaminophen 7.5/325 mg tablet. Resident #1's diagnoses included chronic pain	F 761	Past noncompliance: no plan of correction required.	

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syndrome. Section C (cognitive patterns) of Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/29/23 included a BIMS score of 15. During an interview with Resident #1 on 04/17/23 at 2:20 p.m. they stated they had no issues with getting medications.

Resident #2 missing one Hydrocodone/Acetaminophen 7.5/325 mg tablet. Resident #2's diagnoses included wedge compression fracture of the second lumbar vertebra. Section C of Resident #2's quarterly MDS assessment with an ARD of 03/03/23 included a BIMS score of 5 out of a possible 15 points. The surveyor was unable to interview this resident.

Resident #3 missing two Oxycodone/Acetaminophen 5/325 mg tablets. Resident #3's diagnoses included peripheral vascular disease and cervicalgia (neck pain). Section C of Resident #3's quarterly MDS assessment with an ARD of 04/03/23 included a BIMS score of 15. Resident #3 was complimentary of the facility staff and stated they had no issues regarding medications.

Resident #4 missing two Oxycodone 5 mg tablets. Resident #4's diagnoses included unilateral primary osteoarthritis right knee. Resident #4's admission MDS assessment with an ARD of 03/21/23 included a BIMS score of 15. This resident had been discharged.

Resident #5 missing one Hydrocodone/Acetaminophen 7.5/325 mg tablet. Resident #5's diagnoses included chronic pain syndrome. Section C of Resident #5's admission

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MDS assessment with an ARD of 03/08/23 included a BIMS score of 15. Resident #5 had no complaints regarding their medications.

Resident #6 missing two Oxycodone 5 mg tablets. Resident #6's diagnoses included, burns involving less than 10% of body surface. Section C of Resident #6's admission MDS assessment with an ARD of 03/28/23 included a BIMS score of 10 out of a possible 15 points. Resident #6 was no longer at the facility.

A review of the above residents medication administration records revealed that the medications had been given per the providers orders on the night the medications went missing.

The facility staff provided the surveyor with the results of their investigation which indicated they had completed drug screens on LPN #1 and Certified Nursing Assistant (CNA) #1. LPN #1's drug screen was negative CNA #1's drug screen was "Presumptive Positive" for Benzodiazepines, Buprenorphine, Opiates, and Oxycodone/Oxymorphone. CNA #1 had been terminated due to the positive drug screen and the fact that they did not follow up with the laboratory when the lab services provider attempted to reach out to them regarding their positive drug screen.

04/17/23 3:07 p.m., when asked about the missing narcotics CNA #1 stated they really didn't know what had happened. LPN #1 had asked them if they had observed anyone around their medication cart and they stated they had not. CNA #1 stated they were no longer employed at the facility they had been terminated and they knew they had failed a drug test, they had bought

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the medications off the street, and they were trying to get help.

The facility provided the surveyor with statements from CNA's #3 and #4.

Date of statement 03/28/23. CNA #3 stated the nurse approached them and wanted to know if they had saw anyone around their medication cart to which they replied, they had not. CNA #3 stated CNA #1 was acting strange, vanished several times during the night, and stated they had Xanax in their system.

Date of statement 03/28/23. CNA #4 stated they had not seen anyone around the medication cart being unusual. Everyone seemed to be doing their usual duties. CNA #4 stated their coworker (CNA #1) did not seem to be available as much as normal. CNA #4 stated they went to lunch around 4:07 a.m. and CNA #1 was left on the hall by themselves.

04/18/23 10:56 a.m., LPN #1 stated they had more than one medication cart the night of the incident. They had hidden the medication cart keys under the narcotic book. LPN #1 stated they hated to admit it, but they typically left their medication keys on top of the medication cart. One CNA (CNA #1) was acting odd, they got fidgety and nervous but denied taking any medications. They had acted funny all night, the staff were having a hard time finding them, and they kept going out to their vehicle. When the Sheriff department came to the facility, they asked the staff if they could search their vehicles. CNA #1 went to their car after being asked not to leave the floor. LPN #1 stated the Sheriff did not find anything when they searched the staff's

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vehicle. LPN #1 stated they had been told to keep their keys on them, no one on the floor knew they kept their keys on their medication cart, someone must have been watching, and it would never happen again.

LPN #1 provided the facility with a written statement on 03/28/23 stating they were working West Wing on third shift on 03/27/23-03/28/23 at approximately 8:45 p.m. they had completed their medication pass on A cart and set the key on the back corner of A cart covered with the narcotic book. After passing B cart medication this nurse got keys back off A cart and placed back in pocket. After final medication pass at approximately 6:40 a.m. this nurse was rechecking narcotic drawer to ensure all narcotic this nurse gave was signed out at this time this nurse noticed several narcotics were missing from A cart drawer.

04/17/23, the facility staff provided the surveyor with their policy titled, "Medication Storage." This policy read in part, "...The facility shall store all drugs and biologicals in a safe, secure, and orderly manner...nursing staff shall be responsible for maintaining medication storage...Only persons authorized to prepare and administer medications shall have access to the medication room, including keys..."

04/17/23, the facility staff provided the surveyor with a copy of "Notice of Disciplinary Action" dated 03/28/23. This document named LPN #1 and stated they had been suspended as they had "...left keys on the medication cart resulting in multiple narcotic medication card missing..."

The facility staff provided the survey team with a

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copy of their "QAPI (quality assurance performance improvement) ACTION PLAN" dated 03/28/23. Issue/Concern Medication Keys were not left in nurses possession.
Goals/Objectives/Expected Outcome Licensed nurses will keep medication cart keys in their possession.
Correction: Medication cart narcotic counts reconciled on all floors in facility. Responsible person(s) Director of Nursing/Quality Assurance (QA) or designee. Projected completion date 03/28/23.
System Changes: Education provided to licensed nurses to ensure keys remain in their possession and medication carts are locked at all times when nurse is not present with cart. Responsible person(s) Staff development coordinator or designee. Projected completion date 03/29/23.
Monitoring/QA oversight: Medication carts will be audited for compliance with locking and securing keys weekly X 4, biweekly X 2, and monthly X 2. Responsible person(s) Unit manager or designee. Projected completion date 07/21/23.

The Director of Nursing and QA nurse provided the surveyor with documentation to indicate all narcotic count sheets and medication cards were reconciled on all floors on 03/28/23. Education had been provided to licensed nurses on 03/28 and 03/29/23. Audits were being completed in the medication rooms/cart/resident rooms.

04/18/23 8:55 a.m. LPN #2 (agency nurse) stated they kept their medication keys in their pocket. The surveyor and LPN #2 compared the narcotic medication cards against the narcotic books for Resident #1's Hydrocodone, Resident #2's Hydrocodone, and Resident #5's Hydrocodone and no issues were identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495306	A. BUILDING _____ B. WING _____	C 04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE THERAPY CONNECTION	105 LANDMARK DRIVE STUART, VA 24171

(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
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04/18/23 9:00 a.m., LPN #6 stated they kept their medication cart key in their pocket and denied ever seeing medication cart keys on top of a medication cart.

04/18/23 11:05 a.m. RN #2 stated they knew to always keep their medication keys on them.

04/18/23, interviews were completed onsite with LPN #2, LPN #4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, and Registered Nurse (RN) #2. All these nurses stated they had been inserviced regarding where to keep their medication cart keys.

04/18/23 9:10 a.m., interview with Resident Council President who stated there were no issues with medications.

Throughout the course of the survey no keys were observed to be left unattended on the medication carts.

04/18/23 4:10 p.m., during a meeting with the Administrator, DON, and QA Nurse the issue with the missing and unsecured medications was reviewed.

A plan of correction was in place at the time of the survey this citation is past non-compliance.