STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 7/25/23 through 7/27/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 07/25/23 through 07/27/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey VA00054281-compliant with regulations. The census in this 90 certified bed facility was 87 at the time of the survey. The survey sample consisted of 18 current resident reviews and 3 closed record reviews.	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 and clinical record	F 684	The facility sets forth the following plan of	8/28/23

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

Electronically Signed | 08/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 1 review, facility staff failed to administer a diuretic medication per physician orders for 1 of 18 residents in the survey sample (Resident #20). Resident #20 was admitted to the facility with diagnoses including atherosclerotic heart disease, congestive heart failure, presence of implanted defibrillator, pulmonary hypertension, long-term use of insulin and anticoagulants, Parkinson's disease, type 2 diabetes mellitus, chronic respiratory failure, and essential hypertension. On the Minimum Data Set assessment with assessment reference date 6/5/2023, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. Clinical record review on 7/25/23 revealed an order dated 7/13/23 for metolazone oral tablet 2.5 mg (milligrams) Give 1 tablet by mouth one time only for fluid overload 1 day to be given 30 minutes prior to torsemide. The order was entered for administration on 7/14, 7/24, and 7/31. The surveyor asked LPN #3 to check the clinical record software for administration times for torsemide and metolazone administered on 7/14 and 7/24. The record indicated metolazone administered on 7/14 at 9:29 AM and torsemide administered at 9:50 AM, allowing 21 minutes between administrations. On 7/24/23 the record indicated the resident received metolazone at 8:46 AM and torsemide at 8:49 AM. During a summary meeting on 7/25/23 the surveyor notified the administrator and director of nursing of the concern with timing of medication administration.	F 684	correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 684 1. Resident # 20 medication order was corrected at the time of the survey. 2. Current residents were audited for medication metolazone and no other residents were affected. 3.Staff were educated by the Staff Development Coordinator on following MD orders for proper medication administration per orders by _August 25, 2023. 4.DON/Designee will monitor that medications are given as ordered by tracking the missed documentation report daily for 2 weeks then monthly times 3. Any non-compliance will be reported to the QAPI committee for tracking and trending and any disciplinary action as needed. 5. Date of compliance: August 28, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 2 On 7/26/23 the director of nursing informed the surveyor that the nurse practitioner reviewed the metolazone order, which was written by the cardiologist, and changed the scheduled times of the medications to 6 AM for metolazone and 8 AM for torsemide, therefore ensuring that there would be a sufficient gap between administrations to ensure effectiveness of the torsemide in the future.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any 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	F 756		8/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 756	Continued From page 3 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to act upon pharmacist recommendations for 1 of 18 residents, Resident #40. The findings included: For Resident #40 the facility staff failed to act upon a pharmacist recommendation. Resident #40's face sheet listed diagnoses which included but not limited to anemia, depression, and psychosis. Resident #40's most recent minimum data set with an assessment reference date of 05/12/23 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #40's clinical record was reviewed and contained a "Consultant Pharmacist Medication Regimen Review" form dated 06/17/23 which read in part "See report for any noted irregularities and/or recommendations." Surveyor	F 756	F 756 1. Resident # 40 Pharmacy review recommendation was reviewed with the Nurse Provider and new orders obtained at the time of the survey. 2. Pharmacy reviews for the past 30 days were reviewed and new orders obtained as indicated. 3. DON/Designee was educated on the process for pharmacy recommendation review and the time frame to complete these by Regional Director of Clinical Services by August 25, 2023. 4. DON/Designee will complete pharmacy recommendations for completion and new orders obtained as indicated monthly times 3 Any non- compliance will be reported to the QAPI committee for tracking and trending and any disciplinary action as needed. 5, Date of compliance: August 28, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 756	Continued From page 4	F 756		

could not locate a report in the clinical record.

This surveyor requested and was provided with a copy of a "Consultation Pharmacist Recommendation to Physician" report dated, which read in part "MRR (medication regimen review) Date: 6/17/2023 Federal guidelines state sedative hypnotic drugs should have an attempt at a gradual dose reduction (GDR) quarterly (approximately every 3 months), when used routinely and beyond the manufacturer's recommendations for duration of use. This resident had been taking Melatonin 3 mg since 1/12/2023 without a GDR in last 3 months. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below: Response: () Reduce the dose of Melatonin to: D/C (discontinue) Melatonin." This form was signed and dated by the facility family nurse practitioner on 07/26/23. The director of nursing stated that the form was just reviewed and acted upon on this day.

This surveyor requested and was provided with a facility policy entitled "Medication Regimen Review" which read in part "6. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate. 7. Recommendations are acted upon and documented by the facility staff and/or prescriber. a. The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing."

The concern of not acting upon a pharmacist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 756	Continued From page 5 recommendation was discussed with the administrator, director of nursing and regional nurse consultant on 07/27/23 at 11:30 am. No further information provided prior to exit.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review and during a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5 %. There were two errors in 28 opportunities for a medication error rate of 7.14%. These errors affected Resident #60. The findings included: For Resident #60, the facility staff failed to administer the medication, amlodipine and failed to follow the physician's order for the administration of the medication, Vitamin D3. Resident #60's face sheet listed diagnoses which included but not limited to hypertension and vitamin D deficiency. Resident #60's most recent minimum data set with an assessment reference date of 06/30/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive	F 759	F 759 1. Resident # 60 MD was notified of medication errors and no new orders obtained at the time of the survey. 2. LPN # 1 was educated on following MD orders for administration of medications by Staff Development Coordinator by August 25, 2023. 3, Current Licensed nurses were educated on following MD orders for administration of medications by Staff Development Coordinator by August 28/2023. Current Licensed Nurses will be checked off by Staff Development Coordinator/Designee to assure proper procedure for medication administration. 4. Any non-compliance will be reported to the QAPI committee for tracking and trending and any disciplinary action as needed. 5. Date of compliance: August 28, 2023	8/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 759	Continued From page 6	F 759		

patterns. This indicates that the resident is cognitively intact.

Resident #60's comprehensive care plan was reviewed and contained a care plan for "the resident is at risk for cardiac complications secondary to chronic kidney disease, congestive heart failure, history of myocardial infarction, hyperlipidemia, hypertension, cardiomyopathy, CKD3 (chronic kidney disease 3) ...." Interventions for this care plan include "administer medications as ordered."

This surveyor observed licensed practical nurse ((LPN) #1 administer medications to Resident #60 on 07/26/2023 at 8:20 am. LPN #1 removed a bottle of Vitamin D3 5000 IU (international units) and placed 2 tablets in the medicine cup. LPN #1 administered the Vitamin D3, along with other medications to Resident #60. Surveyor did not observe LPN #1 administer amlodipine to the resident.

This surveyor reconciled Resident #60's medication on 07/26/2023. Resident #60's physician's order summary contained an order which read in part, "Vitamin D3 capsule 125 mcg (5000 UT [units]). Give 5000 unit by mouth one time a day for vit d def (deficiency)" and "amlodipine besylate tablet 10 mg. Give 1 tablet by mouth one time a day related to essential (primary) hypertension."

This surveyor spoke with LPN #1 on 07/26/2023 at 9:30 am regarding Resident #60's medications. Surveyor asked LPN #1 if they had administered Resident #60's amlodipine and LPN #1 stated they had and proceeded to remove Resident #60's medications from the cart. Resident #60's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 759	Continued From page 7 amlodipine was not among the medications in the cart. LPN #1 stated, "I thought I gave it, but I guess not. I'll have to pull it from the Omnicell." LPN #1 removed the amlodipine from the Omnicell and administered it to the resident. Surveyor asked LPN #1 how many Vitamin D3 tablets they had administered to Resident #60, and LPN #1 stated they had administered two, and that's what the order called for. Surveyor asked LPN #1 to review the Vitamin D3 order, and after reviewing the order, LPN #1 stated that the order read to administer one tablet. This surveyor requested and was provided with a facility policy entitled "General Guidelines for Medication Administration", which read in part "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. I. Preparation 6. At a minimum, the 5 Rights-right resident, right drug, right dose, right route, and right time-should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away." The concern of not ensuring a medication error rate of less than 5% was discussed with the administrator, director of nursing, and regional nurse consultant on 07/26/23 at 4:30 pm. No further information was provided prior to exit.	F 759		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System	F 919		8/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 919	Continued From page 8 The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document review, the facility staff failed to ensure 1. the resident communication system relayed calls directly to a staff person or to a centralized staff work area from all residents' rooms and 2 of 2 bathing areas, and 2. call light pull cords were in working order in 2 of 2 bathing areas. The findings were: 1. The residents' call button/bell communication system was not connected to any centralized staff work area or directly to any staff person. During a resident council meeting discussion regarding staff call bell response times, the residents reported their call buttons triggered a visual light above their door to illuminate in the hallway but there was nothing audible when they pressed the button; a handbell had been provided for an audible call bell. Following the resident council meeting which took place on 07/26/23 at 3:00 p.m., the administrator acknowledged the call button communication system was visual, not audible, and residents had been provided a hand bell for audible notifications.	F 919	F 919 1. At the time of survey residents were audited for hand bell in place and if not available hand bells were given to residents. All SPA rooms were locked and had a manual code on the doors so only staff could allow residents into these rooms. 2. Current residents in the center have potential to be affected. 3. DON/Designee will monitor for hand bells in place on daily rounds and if one not in place one will be provided. Quotes have been obtained and contract for new system is in place as of August 7, 2023. System is scheduled to be put in place when company available 4. The results will be reported to the QAPI committee for review and discussion. Once the QA committee determines the problem no longer exist, audits will be conducted on a random basis. 5. Date of compliance : August 28, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 919	Continued From page 9	F 919		

At approximately 4:15 p.m. on 7/26/23, an anonymous facility staff member reported to one surveyor that it had been over a year since the call system stopped working properly and the notification boxes were removed from the nurses' stations. Call bell lights were not observed visually or audibly at any centralized location, only lighting above resident doors.

The survey team tested resident room call buttons on each unit. When the call button was pushed, the light over the resident room door illuminated but that notification was not sent to any centralized system or to any direct staff member. The nurses' stations did not contain any communication system (neither visual nor audible) which showed there was a resident room call button pushed; staff must look down each hall to see whether any lights illuminated over a resident's door. There was no sound heard when the residents' call buttons were pushed. While assessing the call button system, the survey team observed all residents' rooms (both A & B beds) for the presence of hand bells and found 39 of 87 residents did not have a hand bell. The call buttons/cords in the two shower rooms did not send a notification directly to a staff member or centralized staff work area when pushed.

On the morning of 07/27/23, the 39 residents who did not have a handbell the day before were re-assessed by the survey team. Two (2) residents did not have a handbell. One of the two, reportedly did not want one and the other resident was said to probably have it in his pocket. That resident was rarely in his room.

On 07/27/23, the administrator provided communication documents regarding the call bell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 919	Continued From page 10	F 919		

system. A business' letter dated 08/05/21 indicated the repair parts for the existing system were no longer available and recommended replacement. A replacement estimate document dated 08/10/21 was provided. An email from the administrator to a corporate employee dated 03/15/23 read the call bell system needed to be addressed and described the concern.

The administrator, director of nursing and regional nurse were informed of the concern again on 07/27/23 at 11:29 a.m. No other information was provided prior to the exit conference.

2. Six (6) of six (6) call light pull cords present in the TCU Spa (bathing area) and one (1) of three (3) call light pull cords in the PCU Spa (bathing area) did not activate the facility call light system.

On 7/26/23 at 5:09 pm, surveyor and registered nurse (RN) #1 entered the TCU Spa room to test the call light system. The Spa room included six (6) call light pull cords located in a bathroom, two (2) separate shower stalls, an area containing a roll-on scale, and in a storage area. Each of the six (6) pull cords failed to activate the visual call light located in the hall outside of the TCU Spa. The TCU Spa was located behind a coded locked door.

On 7/26/23 at 5:16 pm, surveyor tested the call light system in the PCU Spa (bathing area), and the call light pull cord located in the back left shower stall did not activate the visual call light located in the hall outside of the PCU Spa. The PCU Spa was located behind a coded locked door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRETNA HEALTH AND REHABILITATION CENTER	595 VADEN DRIVE GRETNA, VA 24557

(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 919	Continued From page 11 On 7/26/23 at 5:18 pm, surveyor notified the regional nurse consultant of the call light observations in the TCU and PCU Spa rooms. On 7/27/23 at 9:47 am, surveyor spoke with certified nursing assistant (CNA) #1 and asked what they would do if they were alone in the bathing area with a resident and needed assistance. CNA #1 stated they would use the call light or stick their head out of the door and ask for help. On 7/27/23 at 11:30 am the survey team met with the administrator, director of nursing, and the regional nurse consultant and discussed the concern of the call light pull cords located in the TCU and PCU Spa rooms failing to activate the facility call light system. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/23.	F 919		