

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 000}	INITIAL COMMENTS	{F 000}		11/16/22	
{F 684} SS=E	<p>An unannounced Medicare/Medicaid revisit to the abbreviated Medicare/Medicaid survey conducted 8/23/2022 through 8/24/2022, was conducted 10/11/2022 through 10/12/2022. No complaints were investigated. New findings are identified at the previously cited Federal tags F-684 and F-842. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements.</p> <p>The census in this 117 certified bed facility was 76 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 102 through 113) and one closed record review (Resident 101).</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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 resident interview, observations, clinical record review, and staff interview, the facility staff failed to obtain a physician's order for the application of a hand splint for one (Resident #103) of 13 residents in the survey sample and failed to follow physician's orders for medication administration for three (Resident #103, Resident #102 and Resident #108) of 13 residents in the</p>	{F 684}	<ol style="list-style-type: none"> 1.) An order was written for a hand splint for resident number 103. Prolia injection was administered to resident number 102 as per order. Remeron was administered to resident number 108 as per order. The Scopalamine Patch is available and is being used with the resident. 2.) A 100% audit was done for all residents requiring hand splints to verify that an order is in place. Facility will do a 100% of residents on Prolia, will do 100% audit of residents on Remeron and a 100% audit where the Scopalamine Patch is in use. The facility will ensure that the medications are available. 3.) Therapy staff will receive education for the process for providing alerts to the Nursing for hand splints. Education will be provided to licensed nurses to check for medication availability and the procedure to follow should a medication not be available. 4.) The Director of Nursing or designee will audit orders for hand splints two times weekly times six weeks then monthly times 3 months. All findings will be presented to the QAPI Committee times 3 months to review for continued intervention or amendment of the plan. The Director of Nursing or designee will audit medication delivery packing slips and medication administration records two times weekly 		

times six weeks then monthly times 3 months. All findings will be reported to QAPI times 3 months to review for continued intervention or amendment of the plan.
5.) Allegation of compliance: 11-16-2022.

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

Michael Buckley

TITLE

Administrator 10/20/2022

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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}	<p>Continued From page 1 survey sample</p> <p>The findings include:</p> <p>1a. The facility staff failed to obtain a physician's order for the application of a hand splint for Resident #103. Resident #103's diagnoses included, but were not limited to: history of stroke, hemiplegia/hemiparesis on the left side, dysphagia, gastrostomy tube, diabetes mellitus, vision loss/blindness in the left eye, and dry eye syndrome.</p> <p>Resident #103's most recent MDS (minimum data set - cms assessment tool) was a quarterly assessment dated 08/11/22, in which Section C documented a BIMS (Brief Interview for Mental Status) score of 12 (out of 15), indicating the resident had moderate cognitive impairment in daily decision making skills. Section G assessed Resident #103 as requiring extensive to full assistance from at least one staff person for all ADL's (activities of daily living).</p> <p>On 10/11/22 at approximately 10:30 AM, Resident #103 was observed lying in bed, with the left hand visibly contracted and with no brace/splint in place. When asked if she had a brace or splint for the left hand, Resident #103 nodded her head yes and stated that it had not been put on yet.</p> <p>On 10/11/22 at approximately 11:30 AM, the resident was observed with a splint in place on the left hand.</p> <p>Upon review of the clinical records, no physician's orders and/or information were found regarding a brace/splint for Resident #103's left hand.</p>	{F 684}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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}	<p>Continued From page 2</p> <p>On 10/11/22 at approximately 11:45 AM, LPN (Licensed Practical Nurse) #2 was asked about Resident #103's brace. LPN #2 stated that the resident does wear a brace, but was unsure of the orders pertaining to it. After reviewing the electronic health record, LPN #2 stated that the resident did not have an order to apply the brace.</p> <p>On 10/11/22 at approximately 4:45 PM, the PT (physical therapist - OS #1) was asked for any information regarding a brace for Resident #103. OS #1 stated that they [therapy department] "...make recommendations, such as a splint/brace, and the nurses will put the order in." The OS#1 was made aware that the Resident #103 had a brace in place, but there were no physician's orders found regarding it.</p> <p>On 10/12/22 at approximately 9:00 AM, the PT OS #1 presented the 6/23/22 OT (occupational therapy) discharge summary for Resident #103, which documented "...Hemiplegia...affecting left nondominant side...contracture, left hand...patient will safely wear a palmar guard on left hand for up to 4 hours...will safely wear a palmar guard on left hand for up to > [greater than] 8 hours with minimal...redness, swelling, discomfort or pain...discharge recommendations: 24 hour care and Splint/brace."</p> <p>On 10/12/22 at approximately 11:15 AM, the survey team met with the administrator, interim DON (director of nursing) and the corporate nurse, during which the above findings were presented. No further information and/or documentation was presented regarding the lack of physician orders for the use of the splint/brace for Resident #103.</p>	{F 684}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 3 1b. The facility staff failed to administer scopolamine to Resident #103, as ordered by the physician. Current physician's orders for Resident #103 included the following: "...Scopolamine Patch 72 hour 1 MG/3 days Apply 1 patch transdermally every 72 hours for nausea and remove per schedule...(order date: 08/11/22)..." A review of the October MAR (medication administration record) documented that Resident #103 was not administered the medication (Scopolamine Patch 72 hour) on October 7th and on October 10th. Progress notes for October 7th and October 10th stated that the scopolamine was on order from the pharmacy. The pharmacy was called on 10/12/22 at 8:45 AM and asked why Resident #103's Scopolamine Patch was not available for administration on October 7th and October 10th. OS #2 stated that Resident #103's Scopolamine patch was canceled in error by the pharmacy staff, adding that a fax had been sent by the pharmacy to the facility nursing staff that requested a reorder of the medication to ensure timely delivery. OS #2 stated that the fax was sent to the facility on 09/26/22 and that there had been no response. The pharmacy tech OS #2 stated that a copy of the fax documentation and confirmation would be sent to the facility for surveyor review. When forwarded, the fax documentation read as "...THIS [Scopolamine patch] WAS D/C'D [discontinued] ON 8/26; PLEASE DC AND REENTER IN PCC [point click care]. THANK YOU..." On 10/12/22 at approximately 11:15 AM, the survey team met with the administrator, interim DON (director of nursing) and the corporate nurse. No further information and/or	{F 684}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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}	<p>Continued From page 4</p> <p>documentation was presented regarding why the scopolamine was not available for administration to Resident # 103, as ordered by the physician.</p> <p>2. The facility staff failed to administer Prolia injections to Resident #102, as ordered by the physician. Resident #102's diagnoses included, but were not limited to: Cerebral Palsy, epilepsy, anxiety disorder, vitamin d deficiency and osteoporosis.</p> <p>The most recent MDS (Minimum Data Set - CMS Assessment Tool) was a quarterly assessment dated 07/18/22, in which Section C documented a BIMS (Brief Interview of Mental Status) score of 15, indicating Resident #102 was cogitively intact for daily decision making skills. Section G assessed Resident #102 as requiring extensive to total assistance of two staff members for almost all ADL's (activities of daily living).</p> <p>A review of Resident #102's clinical records revealed a current physician's order for "Prolia solution prefilled syringe 60 mg/ml (milligrams per milliliter) inject 60 mg subcutaneously one time a day every 6 months, starting on the 23rd for one day for age related osteoporosis, 1 dose every 6 months, indefinitely -administered on 9/23/21, due March 23, 2022."</p> <p>According to the Resident #102's March 2022 MAR (medication administration record), the Prolia was administered on March 23, 2022, as ordered, indicating the next dose would be due for administration again, 6 months later, on 09/23/22. A review of the September 2022 MARs revealed that the Prolia injection was not administered on 09/23/22.</p>	{F 684}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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}	<p>Continued From page 5</p> <p>A progress note dated 09/23/22 documented that the Prolia injection was not available at the facility for administration and documented that the pharmacy was aware.</p> <p>Resident #102's physician's orders and MARs were again reviewed for September and October 2022, but no evidence was found that the Prolia injection had been administered, nor was there any follow up and/or correspondence found regarding why the medication was not administered or why the the medication was not available.</p> <p>On 10/12/22 at approximately 9:00 AM, the pharmacy was called regarding the medication. OS# 2 stated that the medication was dispensed by the pharmacy on 09/26/22 and was delivered to the facility on 09/27/22, adding that the medication should have been put in the refrigerator. OS #2 then stated that the medication was signed as received by RN (Registered Nurse) #4.</p> <p>On 10/12/22 at approximately 9:20 AM, RN #4 was interviewed regarding Resident #102 and the medication Prolia. RN #4 stated that she has never administered that medication before and does not recall signing for the medication. The RN stated, "I'm going to be honest...I don't recall seeing it and if I signed for it, I don't remember that."</p> <p>When presented with the above findings, the unit manager looked in each of the medication carts and the refrigerator on that unit to determine if the Prolia was there, but the medication was not found.</p>	{F 684}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801	
(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}	<p>Continued From page 6</p> <p>There was no explanation by RN #4 or the unit manager why the missing medication was not followed up on.</p> <p>On 10/12/22 at approximately 11:15 AM, the administrator, interim DON and corporate nurse were made aware of the above findings, during a meeting with the survey team.</p> <p>No further information and/or documentation was presented prior to the exit conference.</p> <p>3. The facility failed to administer Remeron to Resident #108, as ordered by the physician. A review of Resident #108's chart revealed a physician's order dated 9/22/22 read "Mirtazapine [Remeron] 7.5 MG Give 1 tablet by mouth at bedtime for MDD [major depressive disorder]."</p> <p>Diagnoses for Resident #108 included: Quadriplegia, urinary tract infection, anxiety, and depression. The most current MDS (minimum data set - cms assessment tool) for Resident # 108 was an admission assessment dated 7/13/22, in which Section C assessed the BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating cognitively intact for decision making skills.</p> <p>A review of Resident #108's MAR (medication administration record) reveled that the Remeron was not given, as ordered, on 10/1/22, 10/7/22, and 10/10/22, with each missed dose documented as not available.</p> <p>On 10/11/22 at 3:25 PM, the licensed practical nurse (LPN #1) working on the hall where Resident #108 resides stated that she was an agency nurse and was assigned to Resident #108 on 10/10/22 but did not give Remeron because it</p>	{F 684}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 7 was not available. LPN #1 was then asked to review the medication cart to see if the medication had been filled. LPN #1 was observed doing so, but was unable to locate the medication for administration. LPN #1 was then asked if Remeron is a medication that might be kept as a stock medication. LPN #1 responded that as an agency nurse she did not have access to the "Cubex" (a medication distribution center at the facility). At this time, a facility staff nurse (LPN #2) accessed the Cubex and stated that Remeron 7.5 MG was available, when questioned. LPN#2 also verified that agency nurses were not able to access the Cubex, but added, "The agency nurses should be asking the facility staff nurses to help access the medications." On 3:35 PM the above information was presented to the director of nursing (DON). The DON then went to the unit and reviewed both medication carts, but reported that she was unable to find Resident #108's missing Remeron. The DON said that she would review the invoices from the pharmacy to see when or if the medication was sent to the facility. On 10/12/22 at 7:55 AM the DON presented a packaging slip from the pharmacy documenting Remeron 7.5 MG (30 tablets) was sent to the facility for Resident #108 on 9/23/22. According to the DON, the packaging slip was signed by a nurse who no longer works at the facility. On 10/12/22 at 9:00 AM, a pharmacy tech, Other Staff (OS) #2, was contacted at the pharmacy. OS #2 confirmed that Resident #108's Remeron (30 tablets) were delivered on 9/23/22 and also verbalized the facility had requested a refill of the	{F 684}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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}	<p>Continued From page 8</p> <p>medication on 9/25/22, 9/27/22, 9/30/22, 10/7/22, and 10/10/22. OS #2 explained that the refill was denied due to the medication being reordered too soon.</p> <p>On 10/12/22 at 9:20 AM, Clinical Nurse Educator (OS #3) was interviewed regarding medications being delivered by the pharmacy. OS#3 verbalized, "The delivery person comes to the facility at any given time during the day and sometimes the nurses are really busy. The controlled medications are usually counted when they arrive and the medication invoice is signed off and given to the delivery person, but sometimes, if the nurses are busy, the non-controlled medications are put in the medication room and counted later in the shift."</p> <p>On 10/12/22 at 9:25 AM, a Cubex transaction audit form, with date range of 9/1/22 through 10/12/22 for Resident #108's Remeron was presented. This documented that the Remeron was taken from the Cubex on 10/11/22 at 3:49 PM and again at 4:15 PM.</p> <p>On 10/12/22 at 10:25 AM, the above findings were presented to the administrator, DON, a nurse consultant and the nurse educator. The DON voiced uncertainty regarding if the Remeron for Resident #108 was being administered, since the medication could not be found, along with the repeated refill requests, and limited evidence that the medication was being pulled from the Cubex.</p> <p>No other information was presented prior to exit conference on 10/12/22.</p> <p>F 711 Physician Visits - Review Care/Notes/Order SS=E CFR(s): 483.30(b)(1)-(3)</p>	{F 684}	<p>1. A verbal order has been received regarding the eye infection for resident</p>	

- | | | |
|--|---|--|
| | <p>number #103, and the resident is receiving treatment as per the order.</p> <ol style="list-style-type: none">2. A 100% audit will be done regarding residents having eye infections and the corresponding orders.3. Licensed nurses will receive education on verbal orders and the process for verbal orders.4. The Director of Nursing or designee will audit the treatment records and orders for all residents having eye infections 3 times weekly times six weeks and then monthly times 3 months. All findings will be presented to the QAPI Committee times 3 months to review for compliance or amendment of the plan.5. Allegation of compliance: 11-16-2022. | |
|--|---|--|

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 711	Continued From page 9 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on resident interview, observations, clinical record review, and staff interview, the facility staff failed to provide physician services for one (Resident #103) of 13 residents in the survey sample. From 9/29/22 to 10/11/22, the medical provider failed to write and/or sign an order for an antibiotic medication to treat Resident #103's bacterial conjunctivitis (highly contagious eye infection). The findings include: Resident #103's diagnoses included, but were not limited to: history of stroke, hemiplegia/hemiparesis on the left side, dysphagia, gastrostomy tube, diabetes mellitus, vision loss/blindness in the left eye, and dry eye syndrome. The most recent MDS (minimum data set - cms	F 711		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 711	<p>Continued From page 10</p> <p>assessment tool) was a quarterly assessment dated 08/11/22, in which Section C documented the BIMS (Brief Interview for Mental Status) score of 12 (out of 15), indicating the resident had moderate cognitive impairment in daily decision making skills. Section G assessed the resident as requiring extensive to full assistance from at least one staff person for all ADL's (activities of daily living). The 05/15/22 annual MDS assessment documented that Resident #103 had triggered in the CAAS (care area assessment summary) for vision, indicating the potential need for care planning.</p> <p>On 10/11/22 at approximately 10:30 AM, Resident #103 was observed lying in bed, wiping and rubbing her left eye with her right hand. When asked if she was receiving eye drops for that eye, Resident #103 nodded her head, yes. The resident's left eye was partially closed and had drainage around the eye.</p> <p>A review of the clinical records revealed a provider note dated 09/29/22 and written by Physician's Assistant (OS #4), which documented that the resident was identified and diagnosed with acute bacterial conjunctivitis of the left eye (eye infection) on that date. The provider note documented, "...left eye is fused, some thick green drainage...Diagnosis and assessment...Acute bacterial conjunctivitis of left eye..." This note also documented that based on the symptoms the resident exhibited, the resident would be treated with "erythromycin ointment [an antibiotic medication] 1 cm (centimeter) ribbon twice daily for 7 days."</p> <p>Resident #103's physician's orders were then reviewed for September and October 2022, but</p>	F 711			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 711	<p>Continued From page 11</p> <p>no orders for the antibiotic eye ointment were found.</p> <p>The Resident #103's MARs (medication administration records) and TARs (treatment administration records) for September and October 2022 were then reviewed, but no evidence of this antibiotic ointment was found.</p> <p>Upon review, the current CCP (comprehensive care plan) documented that Resident #103 "...has vision impairment due to left eye partially sewn shut and recurrent problems with dry eyes, reoccurring conjunctivitis [revision on 05/22/22]...administer medications as per MD (medical doctor) orders...assess and observe for effectiveness of medication...encourage proper handwashing...instruct not to touch or rub eyes...observe for drainage, redness, swelling or watery eyes...[revision 09/11/2012]..."</p> <p>On 10/11/22 at approximately 3:30 PM, LPN (Licensed Practical Nurse) #2 was interviewed regarding Resident #103 having a current eye infection, or within the last month, that required a prescribed topical antibiotic ointment to the eye. LPN #2 stated that she was not aware of the resident having an infection or being prescribed an antibiotic eye ointment. Observed reviewing the electronic health record, LPN #2 stated that the resident did not have anything ordered and that she (LPN #2) was unaware of the resident having an eye infection.</p> <p>LPN #2 was made aware of the 9/29/22 provider progress note written by PA#1. Observed reading the note and then reviewing the physician's orders again, LPN #2 again stated that she was not aware of the resident having an infection in</p>	F 711		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 711	<p>Continued From page 12</p> <p>the left eye or of any physician orders for the treatment of an eye infection..</p> <p>On 10/12/22 at approximately 9:00 AM, Resident #103's clinical records were again reviewed, which then included an order dated 10/11/22, that read: "erythromycin ointment 5 mg/gm (milligrams/gram) instill 1 cm in both eyes two times a day for bacterial conjunctivitis for 7 days."</p> <p>On 10/12/22 at 10:50 AM, the Physician Assistant (OS #4) was interviewed via phone regarding Resident #103. OS #4 was made aware of the provider progress note review, along with the resident's clinical records, which revealed that the resident had not been ordered the medication to treat the identified infection on 09/29/22 and the resident was now 14 days without treatment. OS #4 stated that she normally comes to the facility on Thursdays but had received a call from nursing on 09/28/22 (Wednesday) regarding the Resident #103's eye. OS #4 stated that she gave a nurse a verbal order for the erythromycin and to go ahead and get the medication started. When asked which nurse she gave the order to, OS #4 stated that she did not remember the nurse's name. OS #4 then stated that she came to the facility the following day (Thursday/her regular day at the facility) and saw Resident #103, writing the progress note dated 09/29/22 (referenced above) on that day. When asked if she had checked on the ordered medication during her visit to the facility on 09/29/22 or if she had signed the verbal order that she had stated that she'd given a nurse the day before, OS #4 stated that she had not checked on the order, nor signed the verbal order. OS #4 then stated, "Those orders [verbal orders] are generally signed off as batch orders, meaning that they are normally signed off</p>	F 711			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 711	Continued From page 13 every week or so, not necessarily on the next scheduled provider visit." On 10/12/22 at approximately 11:00 AM, LPN #2 was asked about telephone orders received on 9/28/22 for Resident #103. Observed reviewing the electronic health record, LPN #2 stated that she could not find a telephone order for Resident #103. LPN #2 stated that telephone orders are written at the time an order is taken and there are no orders for Resident #103 regarding an eye infection for the time frame in question. The administrator, interim DON (director of nursing) and corporate nurse were made aware of these findings in a meeting with the survey team on 10/12/22 at approximately 11:00 AM. The facility policy on verbal orders was requested and subsequently presented. The policy titled "Verbal Orders" documented "...orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist...those given to the nurse by the physician in person or by telephone, however, are not written by the physician in the medical record...repeat the prescribed orders back to the physician or health care provider...use clarification questions to avoid misunderstandings...enter the order into the medical record...The physician should sign the order on his/her next visit to the facility..." Prior to the exit conference, no further information and/or documentation was provided to evidence that Resident #103 was provided physician services for the timely treatment of the identified eye infection.	F 711			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755	1. The medication Remeron has been administered to resident number #108.		

	<p>The correct amount of Rivastigmine has been issued to the facility by the pharmacy and has been received by resident number #104.</p> <ol style="list-style-type: none"> 2. A 100% audit will be done regarding residents ordered Remeron and Rivastigmine to verify for residents being administered medications and that the correct amounts are being delivered by the pharmacy. 3. Licensed nurses will receive education on administration of medications, checking for availability and the procedure to follow should a medication not be available. 4. A pharmacy representative will provide acknowledgment that pharmacy personnel are provided education on issuing the correct amount of medication to the facility. 5. The Director of Nursing or designee will audit the pharmacy packing slips for accuracy and the medication administration records to verify that medications are administered as per the physician order. 6. Allegation of Compliance: 11-16-2022.
--	---

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801	

(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 755	<p>Continued From page 14 CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§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.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§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 staff interview, clinical record review, observations, and facility document review, the facility staff failed to provide pharmacy services to ensure dispensing and administering medications</p>	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2022
---	--	--	---

NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 15</p> <p>as ordered for two (Resident #108 and 104) of 13 resident's of the survey sample. Resident #108 did not receive Remeron (medication given for depression and as appetite stimulant), as ordered by the physician. For Resident #104, the pharmacy failed to dispense the accurate amount of Rivastigmine (medication for dementia), as ordered by the physician.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Diagnoses for Resident #108 included: Quadriplegia, urinary tract infection, anxiety, and depression. The most current MDS (minimum data set - cms assessment tool) was an admission assessment dated 7/13/22, in which Section C documented the BIMS (Brief Interview for Mental Status) score of 15 (out of 15), indicating cognitively intact for daily decision making. <p>On 10/11/22, Resident #108's medical record included a physician's order dated 9/22/22, which read "Mirtazapine [Remeron] 7.5 MG Give 1 tablet by mouth at bedtime for MDD [major depressive disorder]." A review of Resident #108's MAR revealed that Remeron was not given on 10/1/22, 10/7/22, and 10/10/22, with the reason documented as not being available.</p> <p>During the interview on 10/11/22 at 3:25 PM, licensed practical nurse (LPN #1), who was the nurse working on the hallway where Resident #108 resides, explained that she was an agency nurse and was assigned to Resident #108 on 10/10/22. LPN #1 stated that she did not give Remeron because it was not available. LPN #1 was then asked to review the medication cart to see if the medication had been filled. Review of</p>	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2022	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 16</p> <p>the medication cart did not evidence that Remeron was available for administration. LPN #1 was asked if Remeron is a medication that might be kept as a stock medication. LPN #1 verbalized, as an agency nurse she did not have access to the "Cubex" (a medication distribution center at the facility). At this time a facility staff nurse (LPN #2) accessed the Cubex and and evidenced that Remeron 7.5 MG was available. LPN#2 verified that agency nurses were not able to access the Cubex, but also said, "The agency nurses should be asking the facility staff nurses to help access the medications."</p> <p>On 10/11/22 at 3:35 PM, the above findings were presented to the director of nursing (DON), who then went to the unit and reviewed both medication carts, but reportedly was unable to find Resident #108's missing Remeron. The DON said she would review the invoices from the pharmacy to see when or if the medication was sent to the facility.</p> <p>On 10/12/22 at 7:55 AM, the DON presented a packaging slip from the pharmacy documenting that Remeron 7.5 MG (30 tablets) was sent to the facility for Resident #108 on 9/23/22. According to the DON, the packaging slip was signed by a nurse who no longer works at the facility.</p> <p>On 10/12/22 at 9:00 AM, the pharmacy tech identified as other staff (OS) #2 was contacted at the pharmacy. OS #2 confirmed that Resident #108's Remeron (30 tablets) were delivered on 9/23/22 and also verbalized the facility had requested a refill of the medication on 9/25/22, 9/27/22, 9/30/22, 10/7/22, and 10/10/22. OS #2 explained that the refill was denied due to it being reordered too soon.</p>	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2022	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 17</p> <p>On 10/12/22 at 9:20 AM, the Clinical Nurse Educator (OS #3) was interviewed regarding medications being delivered by the pharmacy. OS #3 verbalized, "The delivery person comes to the facility at any given time during the day and sometimes the nurses are really busy. The controlled medications are usually counted when they arrive and the medication invoice is signed off and given to the delivery person, but sometimes, if the nurses are busy, the non-controlled medications are put in the medication room and counted later in the shift."</p> <p>On 10/12/22 at 9:25 AM, a Cubex transaction audit form, with date range of 9/1/22 through 10/12/22 was presented for Resident #108's Remeron. This documented that the Remeron was taken from the Cubex on 10/11/22 at 3:49 PM and again at 4:15 PM.</p> <p>On 10/12/22 at 10:25 AM the above findings was presented to the administrator, DON, a nurse consultant and a nurse educator. The DON voiced uncertainty regarding if Resident #108's Remeron was actually delivered and said the facility has 24 hours to reconcile with the pharmacy if medications were missing from the delivery. OS #3 verbalized that the expectation is for the nurses to review the invoice against the medications that are being delivered at the time the medications arrive.</p> <p>No other information was presented prior to exit conference on 10/12/22.</p> <p>2. Resident #104's diagnoses included, but were not limited to: Non Hodgkin's lymphoma, dementia, high blood pressure, history of TIA</p>	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 18 (transient ischemic attacks), adult failure to thrive, and depression.</p> <p>The resident's most recent MDS (minimum data set - cms assessment tool) was an annual assessment dated 09/07/22, in which Section C documented a BIMS (Brief Interview of Mental Status) score of 3 (out of 15), indicating severe impairment in daily decision making skills.</p> <p>Resident #104's current physician's orders were reviewed and revealed an order for "...Rivastigmine capsule 1.5 mg (milligram) Give 2 capsules by mouth every 12 hours for dementia..." The September and October 2022 MARs (medication administration records) for Resident #104 included the above order. However, the MARS documented that between September 21st (2022) through October 1st (2022) the resident did not receive the morning doses of the medication on September 21st, 22nd, 24th, 26th, and 27th. The MAR also documented that the resident did not receive the evening doses of medication on September 21st, 25th, 26th, 27th, 29th, and October 1st.</p> <p>The resident's progress notes for September and October 2022 documented that the medication was either not available or on order, for the days and times the medication was not administered on the MAR.</p> <p>On 10/11/22 at 3:25 PM, the licensed practical nurse (LPN #1) working on the hall where Resident #108 resides stated that she was an agency nurse, but had been assigned to Resident #108 on 10/10/22. When questioned further, LPN #1 stated that the Remeron had not been given "...because it was not available." LPN #1 was</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 19</p> <p>then asked to review the medication cart to see if the medication had since been filled. LPN #1 was observed doing so, but was unable to locate the medication for administration. LPN #1 was then asked if Remeron is a medication that might be kept as a stock medication. LPN #1 responded that as an agency nurse, she did not have access to the "Cubex" (a medication distribution center at the facility). A facility staff nurse (LPN #2) accessed the Cubex and stated that Remeron 7.5 MG was available. LPN#2 also verified that agency nurses were not able to access the Cubex, but added, "The agency nurses should be asking the facility staff nurses to help access the medications."</p> <p>On 10/12/22 at approximately 9:00 AM, the pharmacy was called for clarification. The pharmacy tech (OS #2) stated that the pharmacy sent the medication on 09/02/22 (60 pills). OS #2 reviewed the order and stated that a discrepancy was showing in their system and that the order showing was for the resident to have one capsule every 12 hours for 14 days and then two capsules two times a day thereafter. OS #2 was made aware that per the order start date of 04/2022, the order for one pill every 12 hours for 14 days should have expired a long time ago. OS #2 then stated that she did not know why it was still showing up and stated that must have been the problem why the medication was not available. OS #2 then stated that the nurses (at the facility) were trying to reorder the medication and the pharmacy was telling them it was too early to reorder based on the order that they [pharmacy staff]were seeing in the system. OS #2 was made aware that the current remeron order showing on the resident's physician order set was for 2 capsules two times a day and that the 'one</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 755	<p>Continued From page 20</p> <p>capsule twice a day for 14 days' was not seen. OS #2 stated that she would clarify the order and make sure the appropriate amount of medication is dispensed to the facility for administration.</p> <p>The administrator, interim DON (director of nursing) and the corporate nurse were made aware of the above findings in a meeting with the survey team on 10/12/22 at approximately 11:15 AM. Prior to the exit conference, no further information and/or documentation was provided to evidence that the pharmacy provided accurate dispensing of medication as ordered by the physician for Resident #104.</p> <p>{F 842} Resident Records - Identifiable Information SS=D CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential</p>	F 755	<p>1.) Administration of the medication Rivastigmine to resident #104 is being correctly documented. The clinical record for resident #108 has been corrected to indicate that Remeron is available.</p> <p>2.) A 100% audit for residents receiving Rivastigmine and Remeron will be done to ensure the accuracy of the medical records.</p> <p>3.) Licensed nurses will receive education on making accurate entries in the medical record concerning medications.</p> <p>4.) The Director of Nursing or designee will audit pharmacy packing slips and the medication administration records 3 times per week time 6 weeks and then monthly times three months. All findings will be presented to the QAPI Committee times three months to review for compliance or amendment of the plan.</p> <p>5.) Allegation of compliance: 11-16-2022</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	Continued From page 21 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	{F 842}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	Continued From page 22 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff interview, and pharmacist interview, the facility staff failed to ensure complete and accurate clinical records for two (Residents # 104 and 108) of 13 residents in the survey sample. The facility staff inaccurately documented that a medication (Rivastigmine) used to treat dementia was administered to Resident #104, when the medication was not available for administration. For Resident # 108, the clinical record inaccurately documented that Remeron (medication for depression and appetite stimulation) was not available, when the medication was available in a facility medication supply unit. The findings include: 1. Resident #104's diagnoses included, but were not limited to: Non Hodgkin's lymphoma, dementia, high blood pressure, history it TIA (transient ischemic attacks), adult failure to thrive, depression and Alzheimer's dementia. The most recent MDS (minimum data set - cms assessment tool) was an annual assessment dated 09/07/22, in which Section C documented the BIMS (Brief Interview for Mental Status) score of 3 (out of 15), indicating Resident #104 had severe cognitive impairment in daily decision making skills. A review of Resident #104's current physician's orders revealed an order for "...Rivastigmine	{F 842}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	<p>Continued From page 23</p> <p>capsule 1.5 mg (milligram) Give 2 capsules by mouth every 12 hours for dementia..."</p> <p>The Resident #104's September and October 2022 MARs (medication administration records) documented that between September 21st through October 1st the resident did not receive the morning dose (two capsules) of the Rivastigmine on September 21, 22nd, 24th, 26th, and 27th. The MAR's also documented that the resident did not receive the evening dose (two capsules) of Rivastigmine on September 21st, 25th, 26th, 27th, and 29th and October 1st.</p> <p>The progress notes for September and October 2022 documented for the days the medication was not administered, as listed above, that the Rivastigmine was either not available or was on order from the pharmacy, indicating the medication was not available for administration to the resident.</p> <p>On 10/12/22 at approximately 9:00 AM, the pharmacy was called for clarification. The pharmacy tech (OS #2) stated that the pharmacy sent the Rivastigmine on 09/02/22 (60 pills). Reviewing the order, OS #2 then stated that there was a discrepancy showing in their system and that the order showing was for the resident to have one capsule of Rivastigmine every 12 hours for 14 days and then two capsules two times a day thereafter. OS #2 stated that the order must have been filled for the resident to have 1 capsule twice a day, not two capsules twice a day. OS #2 added, "If [Resident #104] was receiving two capsules twice a day, the supply of Rivastigmine would have exhausted on/or around September 17th or 18th."</p>	{F 842}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	<p>Continued From page 24</p> <p>On 10/12/22 at approximately 11:00 AM, the administrator, interim DON and corporate nurse were made aware of these findings in a meeting with the survey team. The facility policy on accurate documentation of clinical records was requested and subsequently presented. This policy was titled, "Documentation in Medical Record", containing "...False information shall not be documented...documentation shall be accurate, relevant, and complete..."</p> <p>No further information and/or documentation was provided prior to the exit conference to evidence that the facility staff were accurately documenting the administration of in Resident #104's clinical records regarding medication administration.</p> <p>2. Documentation on Resident #108's MAR (medication administration record) was not accurate for the administration of Remeron (Medication given for depression and appetite stimulant).</p> <p>Diagnoses for Resident #108 included: Quadriplegia, urinary tract infection, anxiety, and depression. The most current MDS (minimum data set -cms assessment tool) was an admission assessment dated 7/13/22, in which Section C documented the BIMS (Brief Interview for Mental Status) score as 15 (out of 15), indicating that Resident #104 was cognitively intact.</p> <p>On 10/11/22 Resident #108's medical record was reviewed. A physician's order dated 9/22/22 read "Mirtazapine [Remeron] 7.5 MG Give 1 tablet by mouth at bedtime for MDD [major depressive disorder]."</p>	{F 842}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	<p>Continued From page 25</p> <p>A review of Resident #108's MAR (medication administration record) revealed that the Remeron was not given, as ordered, on 10/1/22, 10/7/22, and 10/10/22, with each missed dose documented as not available.</p> <p>On 10/11/22 at 3:25 PM, the licensed practical nurse (LPN #1) working on the hall where Resident #108 resides stated that she was an agency nurse and was assigned to Resident #108 on 10/10/22 but did not give Remeron because it was not available. LPN #1 was then asked to review the medication cart to see if the medication had been filled. LPN #1 was observed doing so, but was unable to locate the medication for administration. LPN #1 was then asked if Remeron is a medication that might be kept as a stock medication. LPN #1 responded that as an agency nurse she did not have access to the "Cubex" (a medication distribution center at the facility). At this time, a facility staff nurse (LPN #2) accessed the Cubex and stated that Remeron 7.5 MG was available, when questioned. LPN#2 also verified that agency nurses were not able to access the Cubex, but added, "The agency nurses should be asking the facility staff nurses to help access the medications."</p> <p>On 3:35 PM the above information was presented to the director of nursing (DON). The DON then went to the unit and reviewed both medication carts, but reported that she was unable to find Resident #108's missing Remeron. The DON said that she would review the invoices from the pharmacy to see when or if the medication was sent to the facility.</p> <p>On 10/12/22 at 7:55 AM the DON presented a</p>	{F 842}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/12/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 842}	<p>Continued From page 26</p> <p>packaging slip from the pharmacy documenting Remeron 7.5 MG (30 tablets) was sent to the facility for Resident #108 on 9/23/22. According to the DON, the packaging slip was signed by a nurse who no longer works at the facility.</p> <p>On 10/12/22 at 9:00 AM a pharmacy tech at the pharmacy was contacted (identified as other staff, OS #2). OS #2 confirmed that Resident #108's Remeron (30 tablets) was delivered on 9/23/22 and also verbalized the facility had requested a refill of the medication on 9/25/22, 9/27/22, 9/30/22, 10/7/22, and 10/10/22. OS #2 explained that the refill was denied due to it being too soon to refill the order.</p> <p>On 10/12/22 at 9:25 AM a Cubex audit transaction form (date range 9/1/22 through 10/12/22) for Resident #108's Remeron was presented and evidenced, documenting that the Remeron had only been taken from the Cubex on 10/11/22 at 3:49 PM and again at 4:15 PM.</p> <p>On 10/12/22 at 10:25 AM the above findings were presented to the administrator, DON, a nurse consultant and OS #3. The facility administrative staff was asked to explain why nurses were documenting on the MAR that the Remeron was not being administered to Resident #104, when it was available in the Cubex. The DON verbalized she felt the MAR was inaccurate due to the inability "...to find the Remeron on the medication carts and there's no evidence that the medication was being pulled from the Cubex."</p> <p>No other information was presented prior to exit conference on 10/12/22.</p>	{F 842}		