STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 An unannounced Medicare/Medicaid survey was conducted 12/11/23 through 12/14/23. 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 VA00055371-Compliant with regulations. The census in this 120 certified bed facility was 116 at the time of the survey. The final survey sample consisted of 24 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, clinical record review, and facility document review, the facility staff failed to follow the providers order for 1 of 24 current residents, Residents #267. The findings included: For Resident #267, the facility nursing staff failed to administer the medications Gabapentin and	F 684	1. For resident 267 all licensed nursing staff were in serviced on medication shortages/unviable medications policy. A pharmacy resource manual was made for each nurse's station which included a complete list of current medications in Omnicell. An audit was performed by DCS to ensure all licensed staff had access to onsite Omnicell. This training will be	2/16/24

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

Electronically Signed | 01/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 Risperdal per the providers orders. Resident #267's diagnoses included, but were not limited to, diabetes, bipolar disorder, peripheral vascular disease, and orthopedic aftercare. There was no completed minimum data set assessment for Resident #267. This resident was alert and orientated to self and place. Resident #267's care plan included the intervention give all medications as ordered. Resident #267's clinical record included provider orders for Gabapentin 600 mg give 0.5 tablet by mouth every 12 hours for neuropathy and Risperdal 2 mg by mouth every 12 hours related to bipolar disorder the order dates were documented as 12/05/23. A review of the clinical record revealed that on 12/05/23 at 9:00 p.m. and 12/06/23 at 9:00 a.m. the facility nursing staff documented a 9 for the medications Risperdal and Gabapentin. Per the preprinted code on the medication administration record (MAR) a 9=other/see nurses note. Further review of the clinical record revealed that on 12/05/23 and 12/06/23 the nursing staff documented medication not arrived from pharmacy, medication on order, and/or awaiting arrival from pharmacy. A review of the Omnicell list (back up drug list) revealed these medications were available for administration. The facility staff provided the survey team with a copy of a policy titled, Medication	F 684	included with all new hires. 2. Quality review conducted by the DCS/designee of medication administration for current nurses. 3. Licensed staff re-educated by the DCS/designee on/by 12/12/2023 regarding medication shortages/ unavailable medication. 4. The ED/DCS/designee to conduct quality monitoring of all licensed nurses medication administration 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 Shortages/Unavailable Medications. This policy read in part, "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action to notify the Pharmacy...If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose..." On 12/13/23 at 10:00 a.m., the Director of Nursing (DON) was made aware of the issue regarding Resident #267's medications Gabapentin and Risperdal not being administered per the provider orders when they were available in the Omnicell. The DON stated the nurses should have obtained the medications from the Omnicell and they would re-educate the nursing staff. On 12/13/23 at 3:30 p.m., during an end of the day meeting with the Administrator and DON the issue regarding Resident #267's medications not being administered per the providers orders was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 689	Continued From page 3 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to ensure the resident environment was free of accident hazards for 1 of 24 current residents, Resident #96. The findings were: Resident #96 possessed both cigarettes and lighter in his room which was against facility policy. The smoking assessment coded Resident #96 as an unsafe smoker prior to the surveyors asking about the facility's smoking policy. Resident #96's admission record contained a list of diagnoses which included but were not limited to chronic kidney disease, major depressive disorder, generalized anxiety disorder, unsteadiness on feet, malignant neoplasm of prostate, secondary malignant neoplasm of bone, disorientation, and psychophysiologic insomnia. The minimum data set with an assessment reference date of 11/24/23 coded the resident's brief interview for mental status a 12 out of 15 in Section C (cognitive patterns). The care plan included but was not limited to a focus area that read the resident was a smoker with interventions which included but were not limited to, instruct resident about the facility policy on smoking: locations, times, safety concerns, and notify	F 689	1. Each resident that was deemed safe after audit performed on 12/13/2023 including resident #96 was given copy by DCS/ED of policy and signed agreement to follow policy. 2. Quality review conducted by the DCS/designee of current residents to ensure patient smoking policy and procedure are being followed. 3. Facility staff re-educated by the DCS/ designee on/by 12/27/2023 regarding patient smoking policy and procedure. 4. The ED/DCS/designee to conduct quality monitoring of residents that are deemed safe smokers to follow policy and procedure3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 689	Continued From page 4	F 689		

charge nurse immediately if it is suspected resident has violated facility smoking policy.

On 12/11/23 between 3:30 p.m. and 4:00 p.m., while meeting residents, two surveyors observed a pack of cigarettes on Resident #96's bed. The resident was sitting next to the bed, in a wheelchair. Resident #96 reported being a smoker and acknowledged the cigarettes on the bed belonged to him. When asked how he got his cigarettes lit, he stated he kept his lighter in his pocket and tapped his shirt pocket with his hand. The resident reported staff did accompany him outside during scheduled smoking times.

Resident #96's clinical record contained a smoking evaluation dated 11/29/2023. Under Observations, number three read in part, the resident was not able to light cigarette safely with a lighter. The summary of evaluation noted the resident was an "Unsafe Smoker" and needed constant supervision while smoking.

The concern about Resident #96 having cigarettes and lighter in his room was discussed with the administrator, the director of nursing (DON), and regional nurse consultant at the end of day meeting on 12/12/23 at 3:35 p.m. The DON reported the facility policy prohibited residents from keeping cigarettes and/or lighters in their room.

The policy and procedure with Subject: "Smoking - Supervised", Document Name: S-406 with an effective date of 11/30/2014 and revision date of 2/07/2020 was reviewed. Under the Procedure, it read in part, "5. The Center will retain and store matches, lighters, etc. for all residents."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 689	Continued From page 5 On 12/13/23, the DON provided the surveyor with a new smoking evaluation for Resident #96 and reported facility staff had performed an audit for all smoking residents. Resident #96's new smoking evaluation dated 12/13/23 determined the resident was a "safe smoker" with the observation portion reading that the resident was able to light cigarette safely with a lighter. On 12/14/23 at approximately 1:30 p.m., the DON acknowledged that regardless of whether Resident #96 was determined a safe or unsafe smoker, no resident was allowed to maintain their cigarettes and/or lighter in their room. No further information was provided prior to the exit conference.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to complete reviews of nurse aides at least every 12 months and failed to provide in-service education based on the outcome of these reviews. The findings were: The facility administration failed to complete	F 730	1. Audit will be conducted by HRC/ED/DCS to determine who is up for 90 day and 1 year evaluation. Licensed staff educated on yearly required CE for licensure. 2. Quality review conducted by the DCS/designee of licensed staff re-educated by the DCS/designee on/by 1/17/2024 regarding yearly required CE	2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 730	Continued From page 6 performance reviews for nurse aides at least every 12 months and therefore failed to provide in-service education which was based on the outcome of the performance reviews. After completing the sufficient and competent nurse staff task, the surveyor asked the human resource manager about nurse aide performance reviews. The nurse aides had received in-service education during their employment however, the education was not based on the outcome of these reviews. On 12/13/23 at the end of day meeting with the administrator and director of nursing (DON), the concern about not having evidence of nurse aide performance reviews was discussed. The administrator said the facility had not provided performance reviews in years and he was unsure why. A policy and procedure with the subject titled, "Employee j [sic]=Job Performance Evaluations" with the document name: HR-405 and an effective date of 11/30/2014 was provided and reviewed. The policy read in part, "It is the policy of The Company to evaluate each employee's job performance on a continual and ongoing basis. Employees will receive an evaluation of their performance prior to the completion of their introductory Period [sic] and annually thereafter." The procedure read in part, "General Provisions Applicable to All Evaluations: Performance evaluations are to be conducted before the completion of the introductory period and annually thereafter. Written performance evaluations are to be prepared by the employee's immediate supervisor in conjunction with the department head, or in the absence of a supervisory, by the	F 730	for licensure. 3. HRC will keep spread sheet of all employees/ new hires and will let DCS know when to conduct a 90 day and yearly evaluation when they are due for each employee. 4. The HRC/ED/DCS/designee to conduct quality monitoring of new hire/yearly evaluations 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 730	Continued From page 7 department head." No further information was provided prior to the exit conference.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review the facility staff failed to ensure medications were available for administration for one of 24 residents, Resident #93. The findings include: For Resident #93, the facility staff failed to ensure the medication Zyprexa was available for administration. Resident #93's face sheet listed diagnoses which included but not limited to dementia, bipolar disorder, depression, and unspecified mood disorder. Resident #93's most recent minimum data set with an assessment reference data of 11/07/23 coded the resident as having both long- and short-term memory loss with severely impaired cognitive skills for daily decision making. Resident #93's comprehensive care plan was reviewed and contained care plans for " ... has potential to be physically aggressive & have increased sexual behaviors r/t Dementia" and " ... uses psychotropic medications r/t dementia with behaviors, BIPOLAR d/o (disorder), depression, insomnia." Resident #93's clinical record was reviewed and contained a physician's order summary which read in part, "Zyprexa Oral Tablet (Olanzapine). Give 2.5 mg by mouth one time a day for Mood related to BIPOLAR DISORDER, UNSPECIFIED."	F 755	1. For resident #93 all licensed nursing staff were in serviced on medication shortages/unavailable medications policy. A pharmacy resource manual was made for each nurse's station which included a complete list of current medications in Omnicell. All licensed staff in serviced to call pharmacy to retrieve medication from backup pharmacy and notify provider. 2. Quality review conducted by the DCS/designee of medication administration for current nurses. 3. Licensed staff re-educated by the DCS/designee on/by 12/12/2023 regarding medication shortages/ unavailable medication. 4. The ED/DCS/designee to conduct quality monitoring of all licensed nurses medication administration 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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	Continued From page 9	F 755		

Resident #93's electronic medication administration (eMAR) record for the months of September and October 2023 were reviewed and contained an entry which read in part, "Zyprexa Oral Tablet (Olanzapine). Give 2.5 mg by mouth one time a day for Mood related to BIPOLAR DISORDER, UNSPECIFIED." This entry was coded "9" on 09/23/23 and 10/26/23. Chart code "9" is equivalent to "other/see nurse's notes."

Resident #93's nurse's progress notes were reviewed and contained notes which read in part, "Effective Date: 09/23/23 Note Text: On order from pharmacy" and "Effective Date: 10/26/2023 Note Text: on order."

Surveyor requested and was provided with a facility policy entitled "Medication Shortages/Unavailable Medications" which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action to notify the Pharmacy. 2. If a medication is unavailable during normal Pharmacy hours: 2.1 A Facility Nurse should call Pharmacy to determine the status of the order, which may be found on Omniview under Pharmacy Connection menu. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, Facility nurse should obtain the medication from Emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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	Continued From page 10	F 755		

Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery, if medically necessary. 3. If a medication is unavailable is discovered after normal Pharmacy hours: 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or 3.2.2 Use of an emergency (back-up) Third Party Pharmacy. 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions. 9. When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR (medication administration record) or TAR (treatment administration record) and in the nurse's notes per Facility policy. 9.1 A description of the circumstances of the medication shortage; 9.2 A description of Pharmacy's response upon notification; and 9.3 Action(s) taken."

Surveyor requested and was provided with a copy of medications available in the facility's emergency medication supply. This list did not contain the medication Zyprexa 2.5 mg.

Surveyor spoke with the director of nursing (DON) on 12/12/23 at 3:30 pm. DON stated that staff should follow the policy for obtaining the medication.

DON provided the surveyor with a copy of an "Education In-service Attendance Record" form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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	Continued From page 11 dated 12/12/23 which read in part "If a medication was not available be sure to check Omnicell (emergency supply) and notify MD." The concern of not ensuring medications were available for administration for Resident #93 was discussed with the administrator and DON on 12/14/23 at 1:30 pm. No further information was provided prior to exit.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility staff review the facility staff failed to ensure three of 24 residents was free of significant medication errors, Resident #82, Resident #215 and #267. The findings included: 1. For Resident #82 the facility staff failed to administer the anticoagulant medication, Xarelto. Resident #82's face sheet listed diagnoses which included but not limited to Alzheimer's disease, atrial fibrillation, and hypertension. Resident #82's most recent minimum data set with an assessment reference date of 09/07/23 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	F 760	1. For resident #82, #215 and # 267 all licensed nursing staff were in serviced on medication shortages/unavailable medications policy. A pharmacy resource manual was made for each nurse's station which included a complete list of current medications in Omnicell. All licensed staff in-serviced on 12/12/2023 to all pharmacy to retrieve medication from backup pharmacy and notify provider. 2. Quality review conducted by the DCS/designee of medication administration for current nurses. 3. Licensed staff re-educated by the DCS/designee on/by 12/12/2023 regarding medication shortages/ unavailable medication. 4. The ED/DCS/designee to conduct quality monitoring of all licensed nurses	2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 12 severely cognitively impaired. Resident #82's comprehensive care plan was reviewed and contained a care plan for " ... is on anticoagulant therapy r/t (related to) Atrial fibrillation." Interventions for this care plan include "Administer ANTICOAGULANT medications as ordered by physician." Resident #82's clinical record was reviewed and contained a physician's order summary which read in part, "Xarelto Tablet 15 mg (Rivaroxaban). Give 1 tablet by mouth at bedtime related to unspecified atrial fibrillation (I48.91)." Resident #82's electronic medication administration record (eMAR) for the month of November 2023 was reviewed and contained and entry which read in part, "Xarelto Tablet 15 mg (Rivaroxaban). Give 1 tablet by mouth at bedtime related to unspecified atrial fibrillation (I48.91)." This entry was coded "9" on 11/26/23. Chart code "9" is equivalent to "other/see nurses notes." Resident #82's nurse's progress notes were reviewed and contained a note, which read in part "11/26/2023 20:14 Note Text: awaiting pharmacy." Surveyor requested and was provided with a facility policy entitled "Medication Shortages/Unavailable Medications" which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately	F 760	medication administration 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 13	F 760		

take action to notify the Pharmacy. 3. If a medication is unavailable is discovered after normal Pharmacy hours: 3.1 A Facility nurse should obtain the ordered medication from the Emergency Medication Supply."

Surveyor requested and was provided with a copy of medications available in the facility's emergency medication supply. This list contained the medication, Xarelto 15 mg tablet.

Surveyor spoke with the director of nursing (DON) on 12/12/23 at 3:30 pm. DON stated that medication should have been removed from the emergency supply, if available there.

DON provided the surveyor with a copy of an "Education In-service Attendance Record" form dated 12/12/23 which read in part "If a medication was not available be sure to check Omnicell (emergency supply) and notify MD."

The concern of not ensuring Resident #82 was free of significant medication error was discussed with the administrator and DON on 12/14/23 at 1:30 pm.

No further information provided prior to exit.

2. For Resident #215, facility staff failed to administer an antibiotic, Ceftriaxone, as ordered by the provider.

Resident #215's face sheet listed diagnoses which included but were not limited to heart failure, cellulitis of right and left lower limbs (bacterial skin infection), sepsis, ST elevation myocardial infarction (heart attack), pasteurellosis (bacterial infection), and acute respiratory failure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 14	F 760		

with hypoxia.

Resident #215's minimum data set with an assessment reference date of 12/05/23 coded the resident's brief interview for mental status a 13 out of 15 in Section C (cognitive patterns). The care plan included a focus area for the resident having pasteurella bacteremia with bilateral lower extremities cellulitis with sepsis. Interventions included but were not limited to "Administer antibiotic as per MD orders."

The electronic clinical record contained a provider order for Ceftriaxone Sodium Intravenous Solution Reconstituted 2 GM. "Use 2 gram intravenously at bedtime for covid PNX for 14 days" to start on 11/30/23 and end of 12/14/23. The Medication Administration Record (MAR) was reviewed. For the 9:00 p.m. dose on 12/09/23, the nurse documented a "9", the code meaning "Other/See Nurse Notes." The eMAR - Medication Administration Note dated 12/10/23 at 12:04 a.m. and written by a licensed practical nurse read, "medication not available pharmacy was contacted and made aware".

On 12/14/23 at approximately noon, the director of nursing (DON) was notified of the concern regarding Resident #215 not receiving the ordered Ceftriaxone dose for 12/09/23 9:00 p.m. The DON stated the pharmacy had not sent that dose of the antibiotic and stated it was common for the pharmacy to send medication doses in batches instead of the complete order's doses.

On 12/14/23 at 1:18 p.m. the nurse practitioner (NP) and DON reported to the survey team that Resident #215 did not receive the Ceftriaxone because the pharmacy had not delivered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 15	F 760		

medication. The NP reported that she and the medical director were both aware of the missed dose and were communicating with the pharmacy; the pharmacy insisted the order was complete. Both the NP and DON acknowledged the resident did miss a dose of the antibiotic and acknowledged their emergency box did not contain the ordered medication (Ceftriaxone 2GM). The DON stated that although the facility does have a backup pharmacy, staff had gotten out of the habit of using it but "we have a good plan to correct that, with education and everything." The DON acknowledged the medication was not available in their emergency medication box.

The concern of not ensuring Resident #215 received an antibiotic as ordered was discussed with the administrator and DON on 12/14/23 at 1:30 p.m.

No further information was provided prior to the exit conference.

3. For Resident #267, the facility nursing staff failed to administer the antibiotic Vancomycin per the providers orders.

Resident #267's diagnoses included, but were not limited to, diabetes, bipolar disorder, peripheral vascular disease, and orthopedic aftercare.

There was no completed minimum data set assessment for this resident. Resident #267 was alert and orientated to self and place.

Resident #267's care plan included the intervention give all medications as ordered.

Resident #267's clinical record included provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 16	F 760		

orders for Vancomycin 125 mg give 1 capsule by mouth every 6 hours for wound for 8 days. The order date was documented as 12/05/23 with a start date of 12/06/23.

A review of the clinical record revealed that on 12/06/23 at midnight, 6:00 a.m., and 12:00 p.m., the facility nursing staff documented a 9 for the medication on the medication administration record (MAR). Per the preprinted code on the MAR a 9=other/see nurses note.

On 12/06/23 the nursing staff documented in the clinical record medication not arrived from pharmacy, medication on order, and/or awaiting arrival from pharmacy.

The facility staff provided the survey team with a copy of a policy titled, Medication Shortages/Unavailable Medications. This policy read in part, "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action to notify the Pharmacy...If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery, if medically necessary...If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..."

On 12/14/23 at 1:30 p.m., during a meeting with the Administrator and Director of Nursing the issue with Resident #267's antibiotic Vancomycin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(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 760	Continued From page 17 was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to dispose of expired laboratory (blood) tubes in 1 of 4 medication rooms. The	F 761	1. Audit was conducted on all medication rooms to ensure all laboratory products are within date, all expired products	2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 100-hall medication room. The findings included: The medication room on 100-hall contained 6 expired laboratory tubes. On 12/13/23 at 9:10 a.m., the surveyor and Licensed Practical Nurse (LPN) #4 completed an observation of the medication room on 100-hall. This medication room was observed to contain 6 yellow top laboratory tubes with an expiration date of 09/30/23. The expired laboratory tubes were mixed in with laboratory tubes that were not expired. LPN #4 acknowledged the laboratory tubes were out of date and placed the expired blood tubes in the sharps box for disposable. On 12/14/23 at 1:30 p.m., the Administrator and Director of Nursing were made aware of the issue regarding the expired laboratory tubes. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761	properly disposed of. 2. Quality review conducted by the DCS/designee of storage of Drugs and Biologicals. 3. Licensed personnel re-educated by the DON/designee on/by 12/13/2024 regarding storage of Drugs and Biologicals. 4. The DCS/designee to conduct quality monitoring of all med rooms with laboratory supplies to ensure products are within date 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly and PRN as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	