STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Healthcare Center	508 Rison Street Danville, VA 24541

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22218 Based on staff interview and clinical record review, facility staff failed to administer an an antibiotic medication per provider orders for 1 of 14 sampled current residents (Resident 30). The findings include: Resident 30 was admitted to the facility with diagnoses including type 2 diabetes mellitus, hypertension, cerebral palsy, obesity, spinal stenosis, obstructive uropathy, and benign prostatic hypertrophy. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the brief interview for mental status and was assessed without signs of delirium or psychosis. The resident exhibited rejecting care 1-3 days of the week prior to the assessment. Clinical record review for antibiotic use revealed a provider order dated 9/20/24 for urinalysis with culture and sensitivity and Ceding 300 mg twice per day for 7 days. On 9/27/24, the laboratory results revealed lactose fermenting gram negative rods. The provider ordered Ertapenem 1 gram intramuscularly daily for 5 days. An Infection control Infection tracker note dated 10/2/24 indicated provider made aware resident previously on Cefdinir x 7 days. Per MD stop Ceftriaxone. On further record review, the surveyor found no order for Ceftriaxone. The resident received 14 doses of Cefdinir as ordered. For Ertapenem, staff documented: 9/28, 9/29- not administered: discontinued; 9/30 not administered: time changed; then administered 9/30 at a later time; 10/1 not administered: medication has not arrived from the pharmacy MD made aware; 10/2 administered. On 10/15/24 at 1:53 PM, the surveyor spoke with the director of nursing (DON) who stated Ceftriaxone was an erroneous entry. The stop order on 10/2 was for Ertapenem. Per Omnicare (pharmacy) invoice, 4 doses of Ertapenem were delivered on 9/29, but did not arrive with the Lidocaine to be used to administer the antibiotic. The Lidocaine arrived on 9/30. The resident received a dose of Ertapenem on 9/30 and another on 10/2/24. There is no explanation for the missed dose on 10/2/24. During a summary meeting on 10/16/24, the administrator, DON, and others were notified of the concern.

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.

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the medical provider documented the action and/or rationale for the action on a pharmacy recommendation, as part of a medication regimen review for (1) one of (5) five residents sampled for medication regimen reviews, Resident #9. The findings included: Resident #9's diagnosis list indicated diagnoses, which included, but not limited to Parkinson's disease, hyperlipidemia, essential (primary) hypertension, chronic respiratory failure, chronic obstructive pulmonary disease, hypothyroidism, atrial fibrillation, schizophrenia, anxiety disorder, major depressive disorder, and bipolar disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Progress notes within Resident #9's clinical record indicated a drug regimen review was completed on 6/12/24 with recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record. Surveyor requested and received the medication regimen review recommendation report completed by the pharmacist for Resident #9 from the regional director of clinical services on 10/11/24. The 6/12/24 Consultation Report read in part .[resident name omitted] receives Buspropion 100 mg (milligrams) every OTHER day. Psych (psychiatric) provider note dated 6/9/24 suggests a trial discontinuation. Recommendation: Please discontinue Buspropion . Review of the Psychiatry Progress Note, dated 6/9/24, read in part, .Patient is being seen today by request to consider GDR (gradual dose reduction) .Recommend to discontinue Wellbutrin (buspropion) .Orders for this visit .Recommend to discontinue Wellbutrin . Further review of the Consultation Report, revealed the medical provider signed the report at the bottom of the report, however, the medical provider did not indicate a Physician's Response to the recommendations. The report was also signed by the DON (director of nursing) on 6/13/24. A review of the active provider orders indicated the recommendation was not addressed, as the medication was active on the order with a start date of 4/4/24. A review of the MARs (medication administration records) for June 2024 through August 2024, indicated Resident #9 continued to receive Buspropion medication as ordered by the physician with no indications of dose reduction or discontinuation. The pharmacist recommended a GDR for Buspropion again on the Consultation Report dated 8/7/24 and the NP (nurse practitioner) declined this recommendation, the report read in part, .because the GDR was clinically contraindicated for this individual as indicated .1. Continued use in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concern was discussed at the end of day meeting on 10/11/24 at 12:15 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received the facility policy titled, Medication Regimen Review which read in part, .6. Facility should independently review each resident's medication regimen .9. Facility should encourage physician/prescriber .receiving the MRR (medication regimen review) and the director of nursing to act upon the recommendations contained in the MRR. 9.1 For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP .9.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it . 10. Facility should alert the medical director where MRRs are not addressed by the attending physician .The attending physician/prescriber should address the consultant pharmacist's recommendations no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations . No further information regarding this concern was presented to the survey team prior to the exit conference on 10/16/24.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. 22218 Based on staff interviews and facility document review the facility staff failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for one agency staff member working in the facility. The findings include: On 10/11/24, surveyors requested employee records of a selection of facility employees and contracted staff for review for compliance with regulations. On 10/15, the administrator reported that staff pulled the licenses of contracted nursing staff over the weekend and discovered that one contracted licensed practical nurse's license (LPN 1) was revoked by the board of nursing on 8/9/2024. The nurse had not notified the facility. A facility investigation was conducted over the weekend. The nurse will not return to the facility. The administrator stated that the company would no longer use that agency as it had not fulfilled requirements of the contract to only provide licensed staff to the facility. The nurse had worked 11 shifts after the license was revoked. Staff interviewed and assessed each resident on the nurse's assignment and reviewed records to determine whether any resident had been negatively impacted by receiving care from this nurse. No negative incidents were found attributable to the nurse's care. The administrator, DON, and others were notified of the concern during a summary conference on 10/16/24.