

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Stanleytown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  240 Riverside Drive Bassett, VA 24055	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>22218</p> <p>Based on observation, resident interview, staff interview, and clinical record review, facility staff failed to administer medicated shampoo as ordered for 1 of 23 residents in the survey sample (Resident #42).</p> <p>Resident #42 was admitted to the facility with diagnoses including psoriasis, above the knee amputation, hypertension, peripheral vascular disease, end stage renal disease, anxiety, depression, bipolar disorder, and schizoaffective disorder. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the Brief Interview For Mental Status and was assessed as without signs of delirium, psychosis, behaviors affecting care, or rejecting care. The assessment indicated the resident was fully dependent for showering and bathing and required substantial/maximal assistance for personal hygiene (includes washing and drying face and combing hair).</p> <p>During initial tour on 4/15/24 at approximately 4:20 PM, the resident's face appeared red and skin was peeling over about 30% of face. The resident's hair showed a significant level of dandruff both peeling from scalp and distributed throughout the resident's hair. The resident's only complaint on interview was psoriasis of her face and scalp which she stated bothered her a great deal. The surveyor asked the resident if three showers per week were offered. The resident stated the last shower had been last week. The resident stated usually received 1-2 showers.</p> <p>Clinical record review on 4/15 revealed a physician order for shower with Neutrogena Tsal external with salicylic acid shampoo 3 times per week on Tuesday, Thursday, and Saturday. The care plan addressed developing psoriasis and the intervention was to treat as ordered until resolved. The KARDEX (a document listing information specifically to inform CNAs of resident-specific care needs) did not mention medicated shampoo or the Tuesday, Thursday, Saturday shower schedule.</p> <p>On 4/17/24 at approximately 2:20 PM, the surveyor spoke with the CNA assigned to the resident, who stated there was medicated shampoo in the resident's grooming supplies which is used when she showers twice per week.</p> <p>The resident's bathing record documented by the CNAs under the Tasks tab in the clinical record included shower-scheduled day shift every Tuesday Thursday Saturday Last 30 days printed on 4/16 documented the resident received 6 showers during that time:</p> <p>Last 30 days scheduled: Last 30 days received:</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>March 19,21,23,26,28,30 18,28</p> <p>April 2,4,6,8,10,12,16 1,4,8,11</p> <p>During a 30 day period, the resident should have received at least 12 showers. Resident #42 received 6 showers during that period. None of the showers occurred on a Saturday.</p> <p>The administrator and director of nursing were notified of the concern during a summary meeting on 4/17/24. On 4/18/22, the director of nursing informed the surveyor that the nurse practitioner had assessed the resident and had ordered a new medicated shampoo to be administered three times per week.</p> <p>04/17/24 4:30 told the DON and corporate consultant informed of issues.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>21227</p> <p>Based on observations, interviews, and facility document review, the facility staff failed to appropriately store and/or serve resident food items.</p> <p>The findings include:</p> <p>The facility staff failed to ensure residents' beverages (orange juice, apple juice, cranberry juice, and iced tea) were appropriately stored and/or served.</p> <p>The following information was found in a facility dietary policy titled Meal Distribution (with a date of October 2019): It is the center policy that meals are transported to the dining locations in a manner that insures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.</p> <p>On 4/16/24 at 9:25 a.m., two (2) carts used to transport breakfast to the facility's residents on the nursing units were noted to have been placed outside a door leading to the facility's kitchen. One of these carts had three (3) pitchers of beverages placed on the top of the cart; the Dietary Services Manager (DSM) reported that the beverages were orange juice, cranberry juice, and apple juice. The other cart had one (1) pitcher of orange juice placed on the top of the cart. One (1) of the orange juice pitchers had a yellow lid; this lid was cracked and had a rubbery, sticky substance on the lid. One (1) of the orange juice pitchers had a blue lid; this lid had a rubbery, sticky substance on the lid. The DSM reported the rubbery, sticky substance was from the stickers used to date the beverage pitchers.</p> <p>On the morning of 4/16/24, the DSM reported that pitchers of orange juice, apple juice, and cranberry juice were removed from the refrigerator and placed on top of the carts used to transport resident meals to the nursing units. The DSM confirmed that the beverage pitchers were not placed on ice or another chilling device. The DSM reported the beverage pitchers, when they are returned with the meal carts, are placed in the refrigerator for future use. The DSM stated the pitchers are dated to indicate when the beverage contained in the pitcher will be discarded.</p> <p>On the morning of 4/16/24, the surveyor, with the DSM present, observed multiple pitchers of iced tea that had been prepared for the midday meal. Five (5) of the iced tea pitchers had sticky, adhesive residue from the stickers used to date the beverage. One (1) of the pitchers of tea was noted to have a cracked lid and a small broken piece of the plastic pitcher missing at the top of the pitcher.</p> <p>On 4/16/24 at 3:38 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services (RDCS). During this meeting, the surveyor shared the aforementioned observations and interviews related to the storage of residents' beverages.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>21227</p> <p>Based on interviews and clinical record review, the facility staff failed to ensure complete and/or accurate clinical records for one (1) of 23 sampled residents (Resident #82).</p> <p>The findings include:</p> <p>Resident #82's clinical record included documentation that indicated the resident was administered medications when the resident was not present at the facility.</p> <p>Resident #82's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/6/24. Resident #82 was assessed as being able to make self understood and as able to understand others. Resident #82's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #82 was assessed as requiring assistance with toileting hygiene, dressing, and bathing.</p> <p>Resident #82's clinical documentation indicated the resident was not present at the facility on 4/5/24. Resident #82's medication administration record (MAR) indicated the following medications were administered at 9:00 a.m. on 4/5/24 (when the resident was not at the facility): cetirizine, cholecalciferol, dexamethasone, losartan, magnesium, nifedipine, fluoxetine, acyclovir, cosopt ophthalmic solution, apixaban, erythromycin ophthalmic ointment, metformin, and metoprolol. Resident #82's blood pressure and pulse were documented as 151/64 and 95 respectively for 4/5/24 at 9:00 a.m.</p> <p>On the afternoon of 4/16/24, the surveyor discussed, with the Director of Nursing (DON), the documentation on Resident #82's MAR indicating medications had been administered on 4/5/24 when the resident was not present in the facility. The DON indicated the documentation of these medications being administered was incorrect documentation.</p> <p>On 4/16/24 at 3:38 p.m., the survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services (RDCS). During this meeting, the surveyor shared the finding of Resident #82's clinical documentation indicating the resident had been administered medications when the resident was not present at the facility.</p>		