STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kings Daughters Community Health & Rehab	1410 North Augusta Street Staunton, VA 24401

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28106 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure medication was available for administration for one of 26 residents, Resident #124, during the medication pass and pour observation. The findings include: During a medication pass and pour observation, conducted on 7/24/24 at 8:00 AM, Resident #124 (R124) was scheduled to receive the medication telmisartan 40 MG. License practical nurse (LPN #3) looked into the medication cart and verbalized that the telmisartan was not available to give. LPN #3 then looked for the medication in the medication room, indicated that the medication was not on hand, called the pharmacy to reorder the medication, and then verbalized that the telmisartan would be sent later in the day. On 7/24/24 at 9:15 AM, the director of nursing (DON) verbalized that the physician had been notified and an order was received to hold the telmisartan and give when the medication arrived from the pharmacy. The physician's order for R124's telmisartan was reviewed and documented: Telmisartan 40 MG Tablet one time a day for HTN [hypertension] dispense at 9:00 AM. On 7/24/24 at 2:45 PM, LPN #3 was asked if the medication in question had been dispensed to R124. LPN #1 said that the telmisartan had not arrived from the pharmacy. LPN #3 was asked to obtain a blood pressure reading at this time, which resulted in R124's blood being noted at 149/71, with a pulse of 71. On 5/24/24 at 4:10 PM, the above findings were presented to the DON, administrator, and nurse consultant. The DON verbalized that the reason the medication was not on hand was because the pharmacy had sent 20 MG tablets of telmisartan, that the staff was giving 2 pills at a time to equal the 40 MG, and had run out of the medication. No other information was presented prior to exit conference on 7/26/24.

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