| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495412 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Nova Health and Rehab | 377 Clonce St<br>Weber City, VA 24290 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>34307<br><br>Based on staff interview and clinical record review the facility staff failed to correctly code a minimum data set (MDS) assessment for 1 of 3 closed record reviews, Resident #86.<br><br>The findings included:<br><br>For Resident #86, the facility staff coded the MDS as acute hospitalization when the resident discharged home.<br><br>Resident #86's face sheet listed diagnoses which included but not limited to hypertension, heart failure, dementia, and anxiety.<br><br>Section A (Identification Information), subsection A2105 (discharge status) of Resident #86's discharge assessment coded the resident as being discharged to Short-Term General Hospital (acute hospital). This MDS has an assessment reference date of 04/12/24 and listed the discharge as unplanned.<br><br>Resident #86's clinical record was reviewed and contained a nurse's progress note dated 04/12/24 which read in part, Res (resident) daughter arrived at facility and was upset about a bill they owed the facility. Stated she was taking her mom home and that she was not paying this bill. Res was educated on the importance of not leaving the facility AMA (against medical advice). Res and daughter verbalized understanding. Res signed AMA and daughter exited the facility with res and all res. belongings. Dr. (name omitted) aware of situation.<br><br>Surveyor spoke with the MDS coordinator on 06/27.24 at 9:15 am regarding Resident #86's discharge status. Surveyor asked MDS coordinator if resident was hospitalized , and MDS coordinator stated they were not. Surveyor then asked MDS coordinator if the MDS was coded correctly, and MDS coordinator stated that it was not, and they would fix it.<br><br>The concern of not coding the resident's MDS correctly was discussed with the administrator, director of nursing, and regional nurse consultant on 06/27/24 at 1:40 pm.<br><br>No further information provided prior to exit. |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>42353<br><br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%. There were 2 medication errors in 26 opportunities for a medication error rate of 7.69%. These medication errors affected Resident #20 and #82.<br><br>The findings included:<br><br>1. For Resident #20, the facility staff failed to administer the probiotic, Lactobacillus Acidophilus as ordered by the medical provider.<br><br>Resident #20's diagnosis list indicated diagnoses, which included, but not limited to Vascular Dementia, Essential Hypertension, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Constipation, and Chronic Kidney Disease Stage 3.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/24/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired.<br><br>On 6/26/24 at 8:57 AM, surveyor observed Licensed Practical Nurse (LPN) #2 prepare and administer Resident #20's morning medications. A reconciliation of the administered medications with the current provider orders revealed a current order for Lactobacillus Acidophilus one (1) capsule once daily for gut health at 9:00 AM. Surveyor did not observe LPN #2 administer Lactobacillus Acidophilus.<br><br>Surveyor returned to LPN #2 at 10:10 AM and inquired about the Lactobacillus Acidophilus, LPN #2 stated they did not give the medication as it did not appear on the MAR (Medication Administration Record) screen for administration. LPN #2 stated some medications were not pulling to the MARs with the new system and the facility was having daily conference calls with the system provider.<br><br>On 6/26/24 at 4:33 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of the facility medication error rate of 7.69% and Resident #20 not receiving medications as ordered.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/27/24.<br><br>2. For Resident #82, the facility staff failed to administer a Lidocaine 5% medicated patch to the resident's leg as ordered by the medical provider.<br><br>Resident #82's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, and Alzheimer's Disease.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/26/24 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/26/24 at 9:07 AM, surveyor observed Licensed Practical Nurse (LPN) #2 prepare and administer Resident #82's morning medications. A reconciliation of the administered medications with the current provider orders revealed a current order for Lidocaine 5% medicated patches to be applied to the leg and lower back once a day at 9:00 AM. Surveyor observed LPN #2 apply a Lidocaine patch to Resident #82's lower back only.<br><br>Surveyor returned to LPN #2 at 10:12 AM and inquired about the order for a Lidocaine patch to the resident's leg. LPN #2 stated Resident #82 had been refusing the patch to their leg, but LPN #2 acknowledged they did not ask the resident if they wanted the Lidocaine patch applied today.<br><br>On 6/26/24 at 4:33 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of the facility medication error rate of 7.69% and Resident #82 not being offered a Lidocaine patch to their leg as ordered.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/27/24. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>42353<br><br>Based on observation, staff interview, and facility document review, the facility staff failed to store all drugs and biologicals in locked compartments on 1 of 2 nursing units, Unit 1.<br><br>The findings included:<br><br>For Unit 1, the facility staff failed to lock an unattended medication cart.<br><br>On 6/26/24 at 8:46 AM, during a medication pass and pour observation, Licensed Practical Nurse (LPN) #1 prepared medications for a resident, entered the resident's room and administered the medications while leaving the medication cart in the hall, unlocked, unattended, and out of direct sight. When LPN #1 returned to the medication cart, they acknowledged the cart was left unlocked.<br><br>Surveyor requested and received the facility policy titled General Dose Preparation and Medication Administration with a revision date of 4/30/24 which read in part, .7. Facility should ensure that medication carts are always locked when out of sight or unattended .<br><br>On 6/26/24 at 4:33 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of LPN #1 leaving a medication cart unlocked and unattended.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/27/24. |