STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. Building B. Wing	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roman Eagle Rehabilitation and Health Care Center	2526 North Main Street Danville, VA 24540

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34307 Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to follow professional standards of practice for the administration of medications. The findings included: During a medication pass and pour observation, the facility staff crushed medications and administered together for 2 of 6 Residents, Resident #140, and Resident #77 Surveyor observed licensed practical nurse (LPN) #2 on 03/07/23 during a medication pass and pour at 8:20 am. LPN #2 prepared medications (4 medications) for Resident #140, crushing all medications together, placing in ice cream and administering together. LPN #2 them prepared medications (7 medications) for Resident #7, crushing all medications together, placing in ice cream and administering together. Surveyor requested and was provided with a facility policy entitled Medication Administration, which read in part C.Crushed medications must be given one at a time, oral or via peg tube. Surveyor spoke with staff development coordinator (SDC) and director of nursing (DON) on 03/07/23 regarding the combined crushing/administering of the medications on 03/07/23 at 10:30 am. The concern of not following professional standards of practice was discussed with the administrator, assistant administrator, DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34307 Based on observation, staff interview, clinical record review, facility document review and during a medication pass and pour the facility staff failed to ensure 1 of 38 residents was free from significant medication errors, Resident #140. The findings included: For Resident #140 the facility staff crushed and administered the non-crushable medication potassium chloride (KCl). Resident #140's face sheet listed diagnoses including but not limited to hypokalemia, hypertension, and anxiety. Resident #140's most recent minimum data set with an assessment reference date of 01/25/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor observed licensed practical nurse (LPN) #2 administer medications to Resident #140 during a medication pass and pour on 03/07/23 at 8:20 am. LPN #2 prepared Resident #140's medications, including a 20 mEq (milliequivalent) KCl tablet, crushing all medications together, placing them all together in ice cream and then administering them to Resident #140. Resident #140's medications were reconciled with the clinical record on 03/07/23 at 9:15 am. Resident #140's clinical record contained a physician's order summary for the month of March 2023 which read in part Potassium CL (chloride) ER (extended release) 20 MEQ (milliequivalent)-One tablet PO (by mouth) daily for supplement. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part Time-release and enteric coated medications should not be crushed. Contact Pharmacist to determine if alternative available. Specific order from physician for alternative or crush medications must be obtained. Surveyor spoke with the staff development coordinator (SCD) and director of nursing (DON) on 03/07/23 at 10:30 am. Surveyor asked SDC and DON if the medication KCl should have been crushed, and DON stated the facility has a list of non-crushable medications, and they would check with pharmacy for clarification. SDC provided surveyor with a copy of a list of Meds That Should Not Be Crushed on 03/07/23 at 10:45 am and stated to surveyor that the KCl should not have been crushed per the list and facility pharmacy. Surveyor reviewed the list, and it contained the medication KCl. The concern of the facility staff crushing a non-crushable medication was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 34307 Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to ensure medications were stored in a secure manner for 1 of 9 medication carts. The findings included: Facility staff failed to secure medications during a medication pass and pour. Surveyor observed licensed practical nurse (LPN) #2 on 03/07/23 during a medication pass and pour. LPN #2 removed a medication bin from the medication cart, placed it on top of the medication cart and prepared resident's medication. After preparing medication, LPN #2 entered resident's room, leaving the medication bin on top of the medication cart, and leaving cart unlocked. Upon returning to the cart, LPN #2 replaced the bin in the cart. Surveyor asked LPN #2 if they normally left the bin on top of the cart, and LPN #2 stated they did not and Can you tell I'm a little nervous? Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, 4. Other A. Security of cart and med room/privacy-Medicine refrigerator, cabinets, and med cart locked when the nurse's back is turned or leaved the cart. The concern of failing to secure medications was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 28567 Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 38 residents, Resident #389 and #110. The findings included: 1. For Resident #389, the facility nursing staff failed to accurately document in the clinical record for the medication Xanax. Resident #389's diagnoses included, but were not limited to, generalized anxiety disorder and major depressive disorder. There was no completed minimum data set (MDS) assessment for this resident. Resident #389's clinical record included an order for Xanax 0.5 mg by mouth three times a day for generalized anxiety disorder. The administration times on the medication administration record were documented as 8:00 a.m., 2:00 p.m., and 8:00 p.m. On 03/03/23 5:28 p.m., Registered Nurse (RN) #2 documented Xanax scheduled for 03/03/23 at 2:00 p.m. not available. 03/07/23 11:37 a.m., RN #2 stated they took over the hall this resident resided on at 2:45 p.m. and did not give any Xanax to this resident as the medication was scheduled at 2:00 p.m. After reviewing their documentation RN #2 stated they began administering medications at 4:00 p.m. and they had documented the Xanax was not available in error. 03/07/23 12:06 p.m., RN #3 stated we moved all the patients to another hall, a family member was in the room, Resident #389 was becoming frustrated stated don't even worry about it and they had forgot to document that the resident refused. 03/07/23 3:00 p.m., the facility staff provided the surveyor with a copy of their policy titled, DOCUMENTATION OF NURSING CARE. This policy read in part, It is the policy of this facility to keep an accurate record of each resident's care .Documentation must be pertinent, concise, reflect the resident's status and include nursing interventions and resident responses . 03/07/23 4:45 p.m., the Administrator, Director of Nursing, Assistant Administrator, and Quality Assurance Nurse were made aware of the issue regarding the documentation of Resident #389's Xanax on 03/03/23. No further information regarding this issue was provided to the survey team prior to the exit conference. 34307 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #110 the facility staff failed to document medication refusals. Resident #110's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, chronic kidney disease and depression. Resident #110's most recent minimum data set with an assessment reference date of 01/14/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part Novolog 100 unit/ml vial-Give 8 units sq (subcutaneously) with meals for DM (diabetes mellitus) Resident #110's electronic medication administration record (eMAR) for the month of March 2023 was reviewed and contained an entry as above. This entry was coded N on 03/02/23 at 12:00 pm. Per the eMAR, chart code N equates not administered. The administration notes section of the eMAR contained an entry which read in part, 11:22AM, 3/02/23 (Scheduled: 12:00PM, 3/02/23; Novolog 100 unit/ml vial) Novolog 100 unit/ml vial-give 8 units S . scheduled for 03/02/2023 12:00PM.accuchec 113 // 03/02/2023 11:22 AM. This entry was electronically signed by licensed practical nurse (LPN) #3. Surveyor spoke with LPN #3 on 03/07/23 at 1:35 pm. Surveyor asked LPN #3 why they had not administered Resident #110's insulin on 03/02/23 at 12:00 pm, and LPN #3 stated that resident's blood sugar was outside of parameters for sliding scale insulin administration. Surveyor then had LPN #3 read resident's insulin order and pointed out that resident is not on sliding scale insulin. LPN #3 then stated that resident refused insulin, and they had just forgotten to chart the refusal. During review of Resident #110's clinical record, several instances of medication refusals were documented. The concern of the facility staff failing to document a medication refusal was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34307 Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to follow established infection control guidelines. The findings included: For one of 9 medication carts, the facility staff left ice cream and ginger ale open/uncovered on top of medication cart. Medication cart was soiled. On 03/07/23, during a medication pass and pour observation, surveyor observed an opened, uncovered cup of ice cream on top of the medication cart. Surveyor also observed an opened bottle of ginger ale, used pill crusher cups, and a white powder-like substance on top of the medication cart. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part,2. Technique I. CART PROPERLY CLEANED-Cart surfaces and medication containers kept clean. Spills wiped immediately and the cart cleaned before and after the med pass. 4. Other E. Infection Control/Aseptic Technique-Juice/applesauce covered? The concern of facility staff not following infection control guidelines was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 21227 Based on observations, interviews, and document review, the facility staff failed to ensure two (2) common bathrooms were equipped with a call system. These two (2) bathrooms were located near the lobby area of the facility; one had a sign reading MEN and the other had a sign reading WOMEN. The findings include: On 3/6/23 at 3:10 p.m., it was observed that a common bathroom with a sign reading MEN was not equipped with a call system. This bathroom was unlocked and accessible to residents, staff, and visitors. This bathroom was able to be locked from the inside. On 3/6/23 at 4:19 p.m., it was observed that a common bathroom with a sign reading WOMEN was not equipped with a call system. This bathroom was unlocked and accessible to residents, staff, and visitors. This bathroom was able to be locked from the inside. On 3/7/23 at 4:49 p.m., the survey team met with the facility's Administrator, Assistant Administrator, DON, and Quality Assurance Coordinator (QAC). The two (2) common bathrooms, which were not equipped with a call system, was discussed. The two (2) bathrooms had been locked and closed, by facility staff members, while the facility staff decided how to address the issue with no call system. On 3/8/23 at 8:02 a.m., the Director of Nursing (DON) provided a policy which addressed responding to resident call system/lights; the DON reported the facility did not have a policy that addressed the location of call system/lights.