STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495183	A. Building B. Wing	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven at Brandermill Woods	2100 Brandermill Pkwy Midlothian, VA 23112

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation, the facility staff failed to provide nursing services that meet with professional standards of care for 1 Resident (#197) in a survey sample of 22 Residents. The findings included: For Resident #197 the facility staff failed to clarify an ambiguous order for an Opioid (oxycodone) and an Opioid Antagonist (Depade). On 3/28/23 a review of the clinical record revealed the following excerpts from the physician orders: 3/24/23 5:42 PM - Oxycodone [an opioid pain medication] 5 mg [milligrams] Give 1 tablet by oral route as needed for pain. 3/24/23 5:42 PM - Depade 50 mg. [An opioid antagonist. Opioid antagonists block the effects of opioids] Give 1 tablet by oral route once daily. On further review of the clinical record, it was found that Resident #197 had been admitted to the facility from the hospital on 3/24/23. Excerpts from the hospital discharge summary are as follows: Page 1 of 5 Hold Naltrexone [Depade] for now to ensure adequate pain control. Page 2 of 5 Start taking these medicines: Oxycodone 5 mg every 4 hours as needed for pain. Naltrexone (Depade) 50 mg by mouth once daily (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/23 at 11:40 AM, an interview was conducted with the Director of Nursing (DON) who stated she was aware that the Resident was receiving Depade and Oxycodone. When asked what the purpose was for giving opioid and an opioid antagonist, she stated that the Resident was an alcoholic and needed to be on Depade. When asked if she found the orders conflicting, she stated they were. When asked if the orders should have been clarified, the DON stated that the admitting nurse goes over the medications with the physician and gets approval for the discharge medications from the hospital. From the [NAME] Website https://journals.lww.com/nursing/fulltext/2003/01001/advice_on_avoiding_lawsuits.11.aspx Don't carry out an order from a health care provider if you have any doubt about its accuracy or appropriateness. Follow your facility's policy for clarifying an ambiguous order. Document your efforts to clarify the order and note whether it was carried out. On 3/30/23 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure the pharmacist recognized irregularities during a Drug Regimen Review for 1 Resident (#197) in a survey sample of 22 Residents. The findings included: For Resident #197 the pharmacy failed to recognize the contraindications of giving Depade and Oxycodone. On 3/28/23 a review of the clinical record revealed the following excerpts from the physician orders: 3/24/23 5:42 PM - Oxycodone (an opioid pain medication) 5 mg (milligrams) Give 1 tablet by oral route as needed for pain. 3/24/23 5:42 PM - Depade 50 mg. (an opioid antagonist) Give 1 tablet by oral route once daily. On further review of the clinical record, it was found that Resident #197 had been admitted to the facility from the hospital on 3/24/23. Excerpts from the hospital discharge summary are as follows: Page 1 of 5 Hold Naltrexone [Depade] for now to ensure adequate pain control. Page 2 of 5 Start taking these medicines: Oxycodone 5 mg every 4 hours as needed for pain. Naltrexone (Depade) 50 mg by mouth once daily On 3/28/23 at 11:40 AM an interview was conducted with the DON who stated she was aware that the Resident was receiving Depade and Oxycodone. When asked what the purpose was for giving opioid and an opioid antagonist, she stated that the Resident was an alcoholic and needed to be on Depade. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/30/23 at approximately 2:00 PM an interview was conducted with the NP who wanted to address the survey team about the medications. The NP stated that the Resident was on Depade for alcohol dependency and had been taking the medication prior to the admission to the facility. She stated that the hospital did hold the medication while she was in hospital. She stated that the rational for re-starting the medication at the facility was that the Resident could have gone into withdrawals. When asked if this medication order seemed conflicting, she stated that it was not because one medication was for pain the other was for alcohol dependency. Surveyors explained the role of the Depade was to block the effects of Narcotics thus working against the effects of the Oxycodone not to prevent withdrawals. According to the SAMHSA.gov (Substance Abuse and Mental Health Services Administration) website: https://www.samhsa. gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone Naltrexone for Alcohol Use Disorder [[NAME]] When starting naltrexone for [NAME], patients must not be physically dependent on alcohol or other substances. To avoid strong side effects such as nausea and vomiting, practitioners typically wait until after the alcohol detox process before administering naltrexone. Patients should not take naltrexone if they: Currently use or have a physical dependence on opioid-containing medicines or opioid drugs, such as heroin, or currently experiencing opioid withdrawal symptoms. On 3/30/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free of unnecessary psychotropic medications for 1 Resident (#16) in a survey sample of 22 Residents The findings included: For Resident #16 the facility staff failed to ensure that as needed (PRN) orders for psychotropic drugs are limited to 14 days. On 3/28/23 during clinical record review it was discovered that Resident #16 had an order for PRN Lorazepam (an anti-anxiety medication). The clinical record revealed the Resident had PRN Lorazepam orders as follows: 1/14/23 8:11 PM - Lorazepam Intensol 2 mg/ml oral concentrate Give 0.5 ml (1mg) by oral route every 4 hours PRN. 'Schedule Every 4 hours PRN for 14 days 1/31/23 3:46 PM - Lorazepam Intensol 2 mg/ml oral concentrate Give 0.5 ml (1mg) by oral route every 4 hours PRN. Schedule - PRN. 2/24/23 8:42 AM - Lorazepam Intensol 2 mg/ml oral concentrate Give 0.5 ml (1mg) by oral route every 4 hours PRN. Schedule PRN Original order date: 1/31/23 Resident #16's order was originally written for 14 days however the subsequent orders were written as just PRN with no end dates. The order written on 1/14/23 was not re-ordered until 1/30/23 (3 days overdue) and the order on 1/31 /23 was not re-ordered until 2/24/23 (10 days overdue) and the current order as of 3/30/23 is (20 days overdue.) The Pharmacy Recommendation stated that per federal guidelines 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in S483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The physician signed the pharmacy recommendation dated 1/26/23 and wrote the word Hospice. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/23 at 11:40 AM, an interview was conducted with the Director of Nursing (DON) who stated she was aware that the Resident was receiving Lorazepam PRN for anxiety. When asked about the prescribing time of PRN anti-anxiety medications she stated she was aware that PRN psychotropic's were limited to 14 days. She stated this was a hospice patient. The DON was informed that hospice does not exclude the physician from proper documentation of diagnosis and rationale for prescribing and expected duration of the treatment. On 3/30/23 at approximately 2:00 PM, an interview was conducted with the Nurse Practitioner (NP) who stated that the reason the medication is prescribed as PRN is because the patient is end of life and on hospice. The patient will be anxious when he or she feels air hunger in the last stages of dying and it needs to be there when the Resident needs it, and we don't know when that will be. The NP was told that the Regulation is not saying they cannot have the medication longer than 14 days it is saying that the appropriate documentation must be in the clinical record to support the orders. On 3/20/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46585 Based on observations, staff interviews and review of the U.S. Food Code, the facility failed to ensure food was stored in accordance with professional standards for food safety. These failures had the potential to increase the prevalence and spread of foodborne illnesses and infection for all 44 facility residents. Findings include: During the initial kitchen tour on 03/28/23 at 11:30 AM with the Director of Dining Services (DDS), inspection of one walk-in freezer revealed four packages with no label to indicate what the food item was or how long it had been in the freezer. The DDS was unable to identify two of the four items. There were seven food items in the freezer that were dated 2021 and appeared freezer burned. These items included pot roast, beef puree, corn, meatballs, beet puree, baked bean puree, sloppy joe sauce, and brisket. There were three food items that were dated 2022 and appeared freezer burned. These items included baked beans, beef, and corned beef. The DSS stated that the kitchen normally did not keep frozen food items longer than six months and confirmed that these 14 items should have been discarded. Further inspection of the dry storage area revealed a container of cheese sauce that had been opened and not dated. Inspection of the walk-in meat and eggs refrigerator revealed an opened container of thousand island dressing, a container of salsa, and a package of provolone cheese that were not dated. The DDS confirmed all these items should have been labeled and dated. Further inspection of the three door freezer revealed opened packages of frozen omelets, French toast, hashbrowns, pork riblets, and eggplant patties that were not labeled or dated. None of these food items were securely closed, exposing them to freezer burn. The DSS confirmed all these items should be properly stored and dated. During an interview on 03/30/23 at 8:03 AM, the Dietary Manager revealed that the DDS went through the freezers and discarded the items that had been there longer than six months. Review of the U.S. Food and Drug Administration's 2022 Food Code revealed, . working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT . shall be identified with the common name of the FOOD. Further review revealed, Date marking of ready-to-eat TCS [Time and temperature controlled] food held for more than 24 hours to control the growth [illness causing bacteria] . 'First-In-First-Out' (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements.