STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495363	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRMONT CROSSING HEALTH AND REHABILITATION	**173 BROCKMAN PARK DRIVE AMHERST, VA 24521**

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 0584 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility staff failed to ensure a homelike environment in one of 16 rooms on the [LOC]. The wall in room [ROOM NUMBER] was scuffed, gouged and without paint in one area. Findings were: During initial tour of the facility on [DATE]20 at approximately 11:00 a.m., a wall in room [ROOM NUMBER] was observed with multiple gouges, peeling/picked wallpaper, and an area that had been partially patched but not painted. At approximately 11:30 a.m., the maintenance director was interviewed about the obseved area. He stated, I believe we've fixed that a number of times.her (the resident in the room) chair hits it and makes those areas, I'll go look at it. He returned and stated, There is a sharp corner on her chair that is doing that (marking the wall). It's her chair so I am going to contact the family about getting it repaired. We'll fix the wall. There's an area there now that we patched, that never got painted. We will take care of it. The administrator and the DON (director of nursing) were informed of the above information during an end of the day meeting on 03/04/2020. No further information was obtained prior to the exit conference on 03/04/2020.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise a comprehensive care plan for one of 25 in the survey sample. Resident #42's care plan was not revised to reflect the use of anticoagulant medication. The findings include: Resident #42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent minimum data set ((MDS) dated [DATE] was an annual assessment, assessed Resident #42 as severely impaired for daily decision making with a score of 5 out of 15. Resident #42's clinical record was reviewed on [DATE]20. Observed on the current physician order [REDACTED]. Two Times Daily Starting 10/09/2019. Order Date: 10/9/2019. Notes: Anticoagulant. A review of Resident 42's comprehensive care plan (CCP) was completed on 03/02/2020. There were no problems, goals, or interventions observed on the care plan to reflect the use of the anticoagulant. On 03/04/2020 at 9:30 a.m., the licensed practical nurse (LPN #1) who provided routine care to Resident #42 was interviewed if Resident #42 was receiving the anticoagulant. LPN #1 stated that yes, Resident #42 continued to receive the medication. On 03/04/2020 at 2:00 p.m., the director of nursing (DON) was interviewed regarding who was responsible for updating the care plans. The DON stated either the MDS coordinator and/or someone in nursing could review and revise the care plans. The DON was interviewed if an anticoagulant medication should be included on the care plans. The DON stated yes, because of concerns with bleeding it should be included on the care plans. The DON stated she would follow-up once she spoke with the MDS coordinator to make sure the care plans were accurate. On 03/04/2020 at 2:16 p.m., the DON returned to the conference room and stated, no the anticoagulant was not put on the care plans and should have been. These findings were reviewed with the interim administrator, director of nursing and assistant director of nursing during a meeting on 03/04/2020 at 2:45 p.m. No additional information was received by the survey team prior to exit on 03/04/2020 at 3:30 p.m.
F 0760 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, facility staff failed to ensure 1 one of 25 residents, Resident #88 was free from a significant, medication error, causing harm. The facility implemented a plan of correction for this deficiency and no other issues were identified during the survey. This is cited as past non-compliance. Findings included: Resident #88 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/22/2020. Resident #88 was assessed as cognitively intact with a total cognitive score of 13 out of 15. On [DATE]20 at 2:00 p.m, Resident #88 was observed sitting in a Broda chair watching television, in the day area with other residents. She was alert, but non-verbal. Resident #88's clinical record was reviewed on [DATE]20 at approximately 2:30 p.m. A clinical note dated 02/07/2020 at 1:12 p.m. included, Charge Nurse made this writer aware that she had administered wrong medication to resident. NP (nurse practitioner) called and made aware at this time. Instructed nurse to assess resident and obtain V/S (vital signs). V/S 195/78, 98.2, 76, 20, 93 Room air. Notified DON (director of nursing) and ADON (assistant director of nursing). Subsequent clinical notes were reviewed and included the following: 02/07/2020 at 1:20 p.m. - Pharmacy called and made them aware, instructed to call MD (physician) or send to (hospital initials) for eval. NP made aware at this time of what Pharmacy recommended. 911 called at this time. 02/07/2020 at 1:25 p.m. - Resident remain alert and talking, neuro check WNL (within normal limits), resident able to move all extremities without any difficulty, she is able to tell me her name, give me her daughters name, and pupils are round and reactive to light. (sic) She is able to squeeze my hand on command. RP (responsible party) called made aware at this time. 02/07/2020 at 1:45 p.m. - Into assess resident at this time, resident remain alert and orient, talking to me. Knows what going on V/s 132/74, 72, 24, O2 sat 93 Room air. (sic) Pupils are not dilating as noted earlier. E[CONDITION] (emergency medical system) Captain arrived to assess resident at this time. Made us aware that he was going to stay with resident until (Name) Transport arrived they was in route. (sic) Resident remain stable, resident daughter in facility at this time. 02/07/2020 at 2:15 p.m. - (Name) transport in here in facility to transport resident to (hospital initials). Resident noted to drowsy, slow to respond, she is still alert and talking to staff and E[CONDITION]. (sic) The Administrator was interviewed on [DATE] at 03:45 p.m. regarding the above mentioned clinical notes. The Administrator stated, We immediately pulled the nurse from the floor. Gave 1:1 education regarding medication pass and pour. She was then monitored for three med passes before she was allowed to administer meds alone on the floor. All facility nurses received education regarding med pass and the facility policy and procedure. We are currently performing random med pass and pour observations. This is the beginning of week 3 of 4. The resident was admitted to the hospital ICU, but was not placed on a ventilator. She received one dose of [MEDICATION NAME] here at the facility. Received another dose of [MEDICATION NAME] at the hospital and was placed on a [MEDICATION NAME] drip. She had problems with her B/P (blood pressure) being high in the hospital that contributed to her lengthy stay. She is now back at the facility at her baseline. Recognizes family. Was up on the unit walking around today. The facility plan of correction (POC) was requested and received on [DATE]20 at 3:50 p.m. Included in the POC was a witness statement completed by the nurse that administered the wrong medications. It included, During preparation of medication for resident in (room number) (Name-Resident #23), (Name-Resident #88) approached cart after lunch to receive her medication. I then stopped to prepare

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495363	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRMONT CROSSING HEALTH AND REHABILITATION	**173 BROCKMAN PARK DRIVE AMHERST, VA 24521**

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 0760 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (Name) Resident #88's medication. (Name) Resident #88's medication was placed into a medicine cup that already had (Name) Resident #23's medication ([MEDICATION NAME] & [MEDICATION NAME]) inside. (Name) Resident #88 took the pills and swallowed them after I handed her water. Unit manager notified. The POS (physician order [REDACTED].#23 included, .[MEDICATION NAME] ER (extended release) 100 mg (milligrams) tablet, oral, every eight hours.[MEDICATION NAME] 30 mg tablet (1 tab) oral, every six hours. These are the two medications Resident #88 received in error on 02/07/2020. The emergency room note included, .Service Date/Time: [DATE] 17:09 (5:09 p.m.).Chief Complaint: Pt (patient) was given someone elses meds by mistake at nursing home. Pt given 100mg ex release [MEDICATION NAME] and 30 of [MED]. Assessment/Plan: 1. Accidental opiate poisoning.Orders: [MEDICATION NAME] 8mg + sodium chloride 0.9% 500 mL.per MD, pt to start at 0.6mg/hr and titrate if needed. Plan to admit.History of Present Illness: Patient presents to the emergency department after she was inadvertently administered another patient's medications at her skilled nursing facility.E[CONDITION] reports that she received 100 mg of extended release [MEDICATION NAME] p.o. (orally) along with 30 mg [MEDICATION NAME] p.o. around 1 PM. She became less alert within an hour and has required 2 doses of [MEDICATION NAME] (1 mg apiece) prior to arrival to maintain her baseline mental status.She is currently asymptomatic. She has no complaints. Vitals & Measurements: HR: (heartrate) 61 (Monitored). RR: 20. B/P: 150/88. SpO2: 97%.General: Awake, alert, elderly, slow in mentation. Eyes: Pupils round and reactive to light 3-4 mm OU (both eyes).Cardiac: Normal S1 and S2.Medical Decision Making: IV [MEDICATION NAME] hung at 0.6mg/hr in concentrated form. Alert and at baseline throughout ED (emergency department) stay. Will need to admit, as meds are long acting. The facility action plan was implemented immediately. Resident was sent to the ER (emergency room) for evaluation on [DATE]. The RN (registered nurse) administering the medications was provided with 1:1 education related to medication pass/pour responsibilities prior to returning to duty. This included, .Dispense meds for one resident at a time only. Follow policy and procedure as it relates to medication administration. Reviewed rights of medication administration and safety checks, completed [DATE]20. The RN will be observed for three days during a med pass to ensure competency with medication pass/pour responsibilities. Successful completion of the competency will be required prior to being allowed to administer medications independently, completed [DATE]. Nursing staff will be re-educated on the policy and procedure for medication pass/pour responsibilities, completed 2/21/2020. Random observations of nurses to be conducted on all three shifts weekly for four weeks to ensure nurses adhering to policy and procedure as it relates to medication administration. This is ongoing and currently in week three of four. Facility policy, Medication Administration Policy, Scope: All Senior Care Services Facilities, Purpose: Is to receive and administer medications in the most accurate and efficient manor (sic) possible.Medication Administration Guidelines, Skill Level: RN, LPN (licensed practical nurse).Policy: 1. The five rights of medication administration are to be followed. Right drug, Right dose, Right client, Right route, Right time. This incident investigation, education and corrective action plan was discussed with the Administrator, DON (director of nursing), and ADON (assistant director of nursing) during a meeting with the survey team on 03/04/2020 at approximately 2:30 p.m. The Administrator stated, If the nurse had not identified her immediate medication error and quickly responded, the outcome could have been much worse. No further information was received prior to the exit conference on 03/04/2020.