

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2023
NAME OF PROVIDER OR SUPPLIER Brandon Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3837 Brandon Avenue Roanoke, VA 24018	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the nursing staff correctly implemented the facility's scheduled/controlled medication monitoring system to accurately account for the facility's scheduled/controlled medications for 1 of 15 current residents. Resident #19.</p> <p>The findings included:</p> <p>For Resident #19, the facility failed to ensure narcotics were accurately accounted for.</p> <p>Resident #19's face sheet included the diagnoses other acute postprocedural pain, hypertension, and presence of right artificial hip joint.</p> <p>Section C (cognitive patterns) of Resident #19's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/22/23 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points.</p> <p>Resident #19's comprehensive care plan included the problem area pain. Approaches included, but were not limited to, administer meds as ordered and encourage resident to report when pain interventions are not effective.</p> <p>The clinical record included a provider order for Oxycodone 5 mg every 6 hours PRN (as needed) for pain.</p> <p>A review of Resident #19's medication administration records (MARs) for 07/2023 revealed that no nursing staff had documented that they had administered Oxycodone to Resident #19 until 07/20/23 when Licensed Practical Nurse (LPN) #1 documented they had administered 5 mg of Oxycodone for pain in their legs at 2:32 p.m. LPN #1 documented the medication was effective. LPN #1 was an agency nurse.</p> <p>The facility staff provided the surveyor with 2 controlled drug records for this medication. Drug record #1 indicating the pharmacy had delivered 16 tablets of Oxycodone on 05/13/23. LPN #6 had signed as the receiving nurse. This form was crumpled and torn. The Administrator stated LPN #1 had taken this form from the facility after their shift but had later returned it. Drug record #2 revealed that the pharmacy had delivered 16 tablets of Oxycodone 5 mg to the facility on [DATE]. LPN #3 had signed for receiving the medication.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07/20/23, LPN #1 documented on controlled drug record #1 that they had removed 1 tablet of Oxycodone 5 mg at 8:00 a.m. LPN #1 documented the word dropped beside of this entry and made a second entry at 8:00 a.m. indicating they had removed a second tablet. LPN #1 did not document they had administered this medication on Resident #19's MAR. LPN #1 documented on the MAR they had administered Resident #19 1 tablet of 5 mg Oxycodone at 1432 (2:32 p.m.) on 07/20/23. However, the count went from #16 to #14 on the controlled drug record (#2) instead of #16 to #15.</p> <p>A review of Resident #19's progress notes revealed LPN #1, or any other nurse had not documented Resident #19 had complained of any pain on 07/20/23.</p> <p>The discrepancy on sheet #2 was identified by LPN #4 when counting narcotics with another nurse on Saturday 07/22/23. LPN #4 left a note and did not immediately report the discrepancy to the administrative staff.</p> <p>09/07/23 10:35 a.m., during a meeting with the Administrator they stated LPN #1 came to the facility and returned controlled record sheet #1 it was crumpled up and torn. They did not ask this nurse to complete a drug test, the agency the nurse worked for was notified, stated they would do an investigation, but they had never reached back out to this facility.</p> <p>LPN #1 had provided the facility with a signed written statement (no date) indicating they had dropped a medication in the residents room on the floor, wasted it in the sharps box but did not have a witness (another nurse) to sign for the disposal of the medication. LPN #1's statement read in part, I dropped a medication in a Patients room on the floor, wasted it in sharps box. I did not have a witness sign it with me. I gave the same women her medication later in the shift, I signed it in the MAR and in the book towards the end of my shift. I made an error by doing so because I gave the medication twice by accident . LPN #1 also wrote that they accidentally took the narcotic sheet home because it was mixed in with other papers on their clipboard.</p> <p>During this interview the surveyor reviewed camera footage with the Administrator, Administrator in Training, and Director of Nursing. On the day of 07/20/23 LPN #1 (identified by facility staff) was observed entering a resident room at approximately 8:12 a.m. The administrative staff identified this room as belonging to Resident #19. LPN #1 was not observed returning to the medication cart and obtain a second dose of Oxycodone to administer to Resident #19. At approximately 2:25 p.m. LPN #1 was observed in the nurses station, observed to open a drawer of the medication cart, leave the nurses station, and walk a few steps down the hallway, turn around and reentered the nursing station. LPN #1 was not observed to enter any residents room(s) prior to turning around and re-entering the nurses station. During the video footage LPN #1 was observed to place a clipboard in their bookbag/backpack.</p> <p>09/07/23 1:23 p.m., during an interview with Resident #19 they stated staff would knock on their door and ask them if they needed anything for pain. Resident #19 voiced no complaints to the surveyor regarding their stay at this facility.</p> <p>09/07/23 2:20 p.m., during an interview with LPN#3 they stated they had counted narcotics with LPN #1 on 07/20/23 they had looked at the paperwork but did not actually look at the medications. A review of the nursing schedule for 07/20/23 indicated an agency nurse (no name) and LPN #3 had both worked this unit on different shifts.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>09/07/23 4:10 p.m., during an interview with LPN #4 they stated they had noticed the discrepancy when counting medications on Saturday (07/22/23) when they arrived at work. There should have been a line for #15 and #14 and there was not a line for #15. The count was correct, but it didn't match up and they had left a note.</p> <p>The administrative staff provided the surveyor with a copy of their policy titled, CONTROLLED SUBSTANCES. This policy read in part, .Accurate accountability of the inventory of all controlled drugs is maintained at all times .</p> <p>09/08/23 8:47 a.m., during an interview with LPN #5 (unit manager) they stated they were notified on Monday 07/24/23 between 6:30 a.m. and 7:00 a.m. by LPN #6 that there was a discrepancy with Resident #19's narcotic medications. They had tried to contact the Administrator but were unable to reach them. They had informed the Administrator when they arrived at work on the same day.</p> <p>09/08/23 8:57 a.m., during an interview with LPN #6 they stated when they arrived to work on Sunday night (07/23/23) they completed a count of the narcotics with LPN #4. When they got to the narcotic page for the Oxycodone LPN #4 had put a sticky note on the narcotic sheet because the numbers were not matching. LPN #4 had asked them what they should do. LPN #6 stated the only thing I could think to do was to tell the unit manager on Monday morning (next morning). The numbers actually matched up but went from #16 to #14 not #16, #15, #14. LPN #6 stated they did not have any complaints from this resident and stated Resident #19 rarely asked for anything.</p> <p>The Administrator provided the survey team with information to indicate Resident #19 was not charged for the medications.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p>		