STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495087	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM HEALTH & REHABILITATION	1945 ROANOKE BLVD SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 10/23/2018 through 10/25/2018. One Complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this certified bed facility was 203 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #2 - #5) and 1 closed record review (Resident #1).	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		11/12/18

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

Electronically Signed | 11/07/2018

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F 842	Continued From page 1	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 2 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to maintain an accurate clinical record with respect to skin condition for 1 of 5 residents in the survey sample (Resident #1). Resident #1 was admitted to the facility on 6/12/18 with diagnoses including altered mental status, bipolar disorder, chronic obstructive pulmonary disease, diabetes mellitus, and muscle weakness. On the 30 day Minimum Data Set assessment with assessment reference date 7/10/18, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The resident's skin was assessed as without skin ulcers or wounds. The surveyor investigated a complaint that the resident had extensive bruising not consistent with falls on arrival at a hospital emergency department. During interviews on 10/25/18, the surveyor interviewed three licensed practical nurses and three certified nurse aids who cared for Resident #1. Each reported that the resident had constantly had multiple bruises on her arms and legs. The unit manager reported that the resident had multiple bruises on the extremities from admission to discharge. The resident's comprehensive care plan listed a focus: Potential for pressure ulcers and skin	F 842	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #1 no longer resides in the center. Skin assessments of current residents were audited for accurate documentation, including bruises. Licensed nurses, physicians, and physician extenders were education regarding accurate and complete skin documentation. Unit Managers (or designee) will review skin assessments weekly x8 weeks and report to DON (or designee). Review in quarterly QA x2 quarters. Completion date: 11/12/18	

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F 842	Continued From page 3	F 842		

impairments. Bruises easily, multiple bruised areas on hands and arms from blood draw attempts (6/21/18). Interventions included skin care, pressure relieving surfaces, and weekly skin assessments.

The weekly skin assessments dated 9/14, 9/7, 8/31, 8/15, and 8/1/18 did not mention bruising. Weekly skin assessment notes dated 8/8, 7/25, 7/18, 7/11, and 7/4/18 document multiple healing bruises on the extremities. Staff reported that the Weekly Skin Assessment form changed between the 8/15 and the 8/31 assessments. The new form no longer contained a note field for additional observations. A post fall nursing progress note dated 8/22/18 documented "scattered aging bruising from previous falls, new bruise right base of thumb resident states they stuck her with a needle this morning for labs".

No physician or nurse practitioner progress notes documented bruising.

During interviews on 10/25/18, The surveyor interviewed three licensed practical nurses and three certified nurse aids who cared for Resident #1. Each reported that the resident had constantly had multiple bruises on her arms and legs. The unit manager reported that the resident had multiple bruises on the extremities from admission to discharge.

The surveyor discussed the concern that the resident's clinical record did not reflect the resident's condition as reported by the resident's caregivers during meetings on 10/25/18.