STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	**300 BLUE RIDGE STREET MARTINSVILLE, VA 24112**

(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 standard survey was conducted 5/9/17 through 5/11/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 300 certified bed facility was 247 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents 1 through 27) and 4 closed record reviews (Residents 28 through 31).	F 000		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		6/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/26/2017

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.

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F 226	Continued From page 1 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review and facility document review the facility staff failed to obtain a Virginia State police criminal background for 1 of 8 employees, employee #8. The findings included: For employee #8 the facility staff failed to obtain a Virginia State Police criminal background check within 30 days of employment per facility policy. Employee #8 was hired on 09/30/16 as a COTA (certified occupational therapy assistant). Employee #8's personnel file was reviewed on 05/10/17. It contained a Virginia State Police criminal background check dated 03/07/17. Surveyor reviewed the facility policy entitled "Screening Hires". This facility policy read as follows: "3. Criminal Record Check for Barrier Crimes b. Request for criminal background check will be electronically submitted to the Central Criminal Records Exchange in order for a reply to be received within thirty (30) days of employment as outlined in the Code of Virginia".	F 226	Submission of this response and Plan of Correction is not a legal admission that a deficiency was correctly cited. It is not to be construed as an admission of interest against the facility, the Administrator, Director of Nursing or any employee, agent, or other individuals who draft or may be discussed in this response or the Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged nor the correction of any conclusions set forth in this allegation by the survey agency. For the deficiencies cited during this survey, this facility has developed and implemented a facility-wide system to assure correction and continued compliance with the regulations. This facility will provide a complete copy of the deficiency list to the QAA Committee for review and appropriate actions.	

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F 226	Continued From page 2 Surveyor spoke with DPS (director of professional services) on 05/10/17 at approximately 1300. DPS stated that employee #8 was hired through a contract service and the contract service was supposed to obtain the background check. DPS stated that he did not know why this had not been completed on time. The concern of not obtaining the criminal background check in accordance with facility policy was discussed with the administrative team during a meeting on 05/10/17 at approximately 1445. No further information was provided prior to exit.	F 226	We would like you to accept this PoC as our credible allegation of compliance. Credible Allegation of Compliance The facility will develop/implement policies to prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. A. Employee # 8□s criminal background check was not completed within the 30 days. There were no adverse effects noted to our residents. The Administrator notified the rehab therapy contract company of their non-compliance with the requirement of the Criminal Background Checks to be completed within 30 days of employment. B. An audit was completed on all the therapy personnel for hire dates and BCI dates to ensure compliance. C. To ensure that the deficient practice will not recur, the Administrator will review all new-hire contract staff (therapy & Healthcare Services) records for hire date and criminal background check to ensure continued compliance. D. This will be monitored and measured through the weekly QA meeting. The facility will be in substantial compliance by June 15, 2017	
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		6/15/17

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F 252	Continued From page 3 CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure a clean, comfortable and homelike environment in the facility. The Findings Included: On May 9, 2017 at 11:15 a.m. the surveyor entered the facility on the first floor of the facility. The surveyor noted a pervasive odor of urine.	F 252	The facility will provide a safe, clean, comfortable and homelike environment for all residents. The (5) soiled ceiling tiles at the entrance of the 3 north unit, ceiling tile in hallway by room 138 on 1 north, 4 ceiling tile in hallway near room 167 on 1 south have all been replaced per maintenance. The Maintenance Director or designee will complete an audit on all units for any	

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F 252 Continued From page 4

On May 9, 2017 at 1 p.m. the surveyor made an initial tour of the facility. The surveyor made the following observations:

On the third floor the surveyor observed five (5) soiled ceiling tiles at the double doors entering the unit. In the shower room had a pervasive odor of urine. Rooms 357 and 351 had soiled privacy curtains. The privacy curtains were soiled with a brownish debris. Dead bugs were observed in the hallway overhead florescent lights at rooms362 and 373. The chairs in the dining room were in poor repair. The chairs were torn and visibly soiled. The dark finish dining tables had the finish worn away, exposing a light wood color. The surveyor observed that six (6) of the overhead florescent lights in the dining room had dead bugs in them.

On the second floor on the 2 North Unit the surveyor observed dead bugs in the hallway overhead florescent lighting near rooms 255 and 261. The unit smelled of urine. The shower room on the 2 North unit had four (4) broken tiles. The shower chair was dirty and the back rest, which was a mesh material, was ragged (appeared to be like dry rotted) and needed to be replaced. The shower stretcher, which also was made out of a mesh material, was jagged, like dry rot, and needed to be replaced. The padding on the shower stretcher was cracked and peeling and needed to be replaced. Lastly the lower portion of the tiled walls and crevices where the walls met with the floors were soiled with what appeared to be mildew, which was dark brownish in color.

On the 2 South Unit the surveyor observed dead bugs in the hallway overhead florescent lighting

F 252

soiled ceiling tiles and will take corrective action to have them replaced. All units will be monitored by the facility QA team along with the senior management to ensure continued compliance and will be ongoing and will be measured in the weekly QA meeting.

Corrective action has been accomplished for units identified with urine odors, 3 North shower room, 2 North unit, 1 North unit and 1 South unit by housekeeping. Odors have been eliminated. Housekeeping supervisors and/or designee will do a morning and late afternoon walkthrough on all units to assess for odors and take measures to eliminate at that time. Unit Coordinators, DON, DOPS, Supervisors and Administrator have been re-inserviced to report odors when identified so that this can be corrected within a timely manner. All units will be monitored by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting.

The Housekeeping Supervisor has replaced the soiled privacy curtain for rooms 357 and 351 on 3 North. An audit will be completed on all units for soiled privacy curtains by the Housekeeping Managers and any found to be soiled will be replaced with clean curtains. All staff will be inserviced to report to the Housekeeping Supervisor of any soiled privacy curtain to be changed out. All units will be monitored by the QA team and senior management for continued

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F 252	Continued From page 5 near rooms 212 and 224. On the 1 North Unit the surveyor observed the shower room. The shower chair was dirty and the back rest, which was a mesh material, was ragged (appeared to be like dry rotted) and needed to be replaced. The shower stretcher, which also was made out of a mesh material, was jagged, like dry rot, and needed to be replaced. The padding on the shower stretcher was cracked and peeling and needed to be replaced. Broken tiles were also observed in the shower room. Additionally the lower portion of the tiled walls and crevices where the walls met with the floors were soiled with what appeared to be mildew, which was dark brownish in color. The unit smelled of urine. Lastly the surveyor observed soiled ceiling tiles in the hallway near the nurses' station and near room 138. On the 1 South Unit the surveyor observed a pervasive odor of urine. The surveyor observed the shower room. The shower chair was dirty and the back rest, which was a mesh material, was ragged (appeared to be like dry rotted) and needed to be replaced. The shower stretcher, which also was made out of a mesh material, was jagged, like dry rot, and needed to be replaced. The padding on the shower stretcher was cracked and peeling and needed to be replaced. Four (4) broken tiles were also observed in the shower room. Lastly the lower portion of the tiled walls and crevices where the walls met with the floors were soiled with what appeared to be mildew, which was dark brownish in color. In the hallway near room 167 four (4) ceiling tiles were soiled with reddish brown debris. On May 11, 2017 at 10 a.m. the surveyor made a	F 252	compliance and will be on-going and will be measured in the weekly QA meeting. Housekeeping Supervisor and or/designee have removed the dead bugs out of the light fixture in the hallway by rooms 362 & 373 and (6) in the dining room on 3 North, hallway lights by rooms 255 & 261 and hallway lights by rooms 212 & 224 on 2 South. The Housekeeping Supervisor and/or designee will complete an audit of all lighting fixtures for dead bugs and remove as needed throughout the facility. All staff will be inserviced to report any bugs noted in the light fixtures to the Housekeeping Supervisor. All units light fixtures will be monitored by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting. Maintenance Supervisor has removed the torn chairs in the 3 North dining room. The soiled chairs will be cleaned by the Housekeeping Supervisor and or/designee. The Housekeeping Supervisor and/or designee will do an audit on all chairs for cleanliness and set up a cleaning schedule to have all completed. The Maintenance Director and or/designee will complete an audit of all the dining room chairs in need of repair and set up schedule to get completed and if not able to repair will be removed starting with 3 North then the second floor then the first floor. The Maintenance Supervisor and or designee will do an audit of all dining room tables which have	

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F 252	Continued From page 6 tour of the facility with the Maintenance Director (MD) and Corporate Compliance Nurse (CCN). The surveyor specifically pointed out her observation to the MD and CCN. On May 11, 2017 at 11 a.m. the survey team met with the Chief Executive officer (CEO), Administrator (Adm), Director of Nursing (DON), Director of Professional Services and the CCN. The surveyor informed the Administrative Team (AT) of the environmental issues and that the facility staff were not maintaining the facility in a clean, comfortable and homelike environment. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a clean, comfortable homelike environment in the facility.	F 252	the finish worn off and will have tables repaired/stained. Dining room furniture on all units will be monitored by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting. The Maintenance Supervisor and/or designee will complete an audit on all shower rooms for broken tiles. The Maintenance Supervisor and or/designee will have the (4) broken tiles repaired on the 2 North unit and on 1 South unit shower room and any other broken tiles in the facility. All unit shower rooms will be monitored for broken tiles by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting. The shower chairs on 2 North, 1 North, and 1 South have been cleaned by housekeeping. Maintenance Supervisor has ordered the mesh backrest for the shower chairs and will be replaced when received. The Maintenance Supervisor and/or designee will audit all the shower chairs in need of new backrest and will replace as needed. The Housekeeping Supervisor and or/designee will clean all shower chairs within the facility and set up a cleaning schedule to maintain cleanliness. The unit shower chairs will be monitored by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting.	

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F 252	Continued From page 7	F 252	The stretcher shower bed pads have been ordered for 2 North and 1 South and will be replaced when received by maintenance. The 1 North unit shower received a new stretcher shower bed on 5/22/17. Maintenance Supervisor and or/designee will audit all stretcher shower beds and will repair and/or replace as needed. All units shower equipment will be monitored by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting. The shower room�s ceramic tile on 2 North, 1 North and 1 South have been cleaned and free of what appeared to be mildew. The Housekeeping Supervisor and/or designee will complete an audit of all shower rooms for dark brownish mildew-like areas and clean as needed and set up a cleaning schedule to be maintained. All unit shower room ceramic tile will be monitored for cleanliness by the QA team and senior management for continued compliance and will be ongoing and will be measured in the weekly QA meeting. The facility will be in substantial compliance by June 15, 2017.	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		6/15/17

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F 278	Continued From page 8 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate comprehensive MDS (minimum data set) for 1 of 31 Residents, Resident #20. The findings included:	F 278	A. Corrective action has been accomplished for resident #20; the MDS has been corrected to reflect hospice status. B. A review of all residents receiving hospice care have been audited to identify	

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F 278	Continued From page 9 For Resident #20 the facility staff failed to code hospice status on the MDS. Resident #20 was admitted to the facility on 03/10/17. Diagnoses included but not limited to cancer, anemia, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, anxiety, and chronic obstructive pulmonary disease. The most recent MDS with an ARD (assessment reference date) of 03/16/17 coded the Resident as 12 of 15 in section C, cognitive patterns. Section O, special treatments, procedures and programs, which includes hospice care, indicated that Resident #20 had not received any special services. Resident #20's clinical record was reviewed on 05/10/17. It contained a form entitled "....(agency name omitted) Certification Statement of Attending Physician and Medical Director" which read in part "I certify that ...(Resident #20) is terminally ill with a life expectancy of six months or less...." and "I confirm that I have composed this narrative based on my review of the patient's medical record...". This form was dated 03/13/17 and signed by the facility medical director. Resident #20's clinical record also contained a nurse's noted dated 03/15/17 which read in part "Resident was admitted to hospice...." The concern of the miscoded MDS was discussed with the administrative staff during a meeting on 05/11/17 at approximately 1100. No further information was provided prior to exit.	F 278	other incidents having the potential to be affected by the same deficient practice. No other residents were found to be affected. C. To ensure that the deficient practice will not recur, the following measures will be put into place. A review of all residents receiving hospice care will be conducted by the MDS Coordinator and the MDS nursing staff. This review will include emphasis on correct documentation that accurately reflects the resident□s status. Review results will be collected by the Director of Nursing (DON) and Director of Professional Services (DOPS) monthly and reported at the weekly Q.A. meeting and quarterly Q.A. Committee and to ensure its effectiveness and that the deficient practice does not recur. D. Senior nursing staff, including all unit coordinators, MDs nurses were re-inserviced on the MDS assessment and how it must accurately reflect the resident□s status. The facility will be in substantial compliance by June 15, 2017.	

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F 323	Continued From page 10	F 323		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide a care-planned fall intervention (fall mattress @ bedside) for 1 of 31 residents (Resident #1) who had a history of falls. Findings:	F 323	The facility will ensure that the resident□s environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents for resident #1 and all other residents. A. Corrective action has been	6/15/17

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Continued From page 11

The facility staff failed to provide a care-planned fall intervention (fall mattress @ bedside) Resident #1, who had a history of falls. The resident's clinical record was reviewed on 5/9/17 at 3:00 PM.

Resident #1 was admitted to the facility on 4/28/14. Her diagnoses included: Malnutrition, anxiety, hypertension, heart failure and dementia.

The resident's latest MDS (minimum data set) assessment dated 3/2/17 coded the resident with serious cognitive impairment. She required the assistance of at least one nursing staff member for assistance with all the ADLs (activities of daily living). This MDS triggered the resident as a high-risk for falls and the decision was made to care plan interventions for same.

Resident #1's CCP (comprehensive care plan) reviewed and revised on 3/13/17 documented the resident at a high risk for major injuries from falls, due to her previous history of falls. The interventions for staff implementation included "mattress on floor beside bed to minimized the resident impact with floor - resident falling frequently".

On 5/9/17 at 11:30 AM & 2:46 PM and on 5/10/17 at 8:30 AM the resident was observed in her bed. She did not have a mattress on the floor by the bed during any of those observations.

On 5/10/17 at 3:30 PM the surveyor informed the facility CEO, administrator, DON, and CN (corporate consultant) of these findings. No additional information was provided.

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accomplished for those residents found to have been affected by the deficient practice as described in the following.

1. Resident #1's comprehensive care plan has been re-evaluated for fall interventions with fall mattress at bedside, and noodles to be placed on residents bed at all times.

B. All clinical records will be reviewed by senior nursing staff and MDS staff to identify other residents who have the potential to be affected by the same deficient practice. The facility has developed an audit tool to be used by nursing staff conducting the records review. This review will include emphasis on interventions on fall prevention, special equipment, mats on floor, and noodles to (R) or (L) side to prevent falls.

C. Re-inservices will be given to nurses on care plan fall prevention and the importance of safety equipment to assure that the deficient practice does not recur.

D. The monitoring report form from the unit MDS nurse to the DON and DOPS, will be collected by the DON monthly, and reported at the quarterly Q.A. Committee. The monitoring process will continue by the MDS nurses, charge nurses, and Q.A. team members for continued compliance to assure its effectiveness so that the deficient practice does not recur.

The facility will be in substantial compliance by June 15, 2017.

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F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in	F 329		6/15/17

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an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 1 of 31 residents was free of an unnecessary medication (Resident #24). Resident #24 received one extra dose of the antibiotic Doxycycline.

The findings included:

The facility staff administered fifteen (15) doses of Doxycycline 100 mg (milligrams) instead of the fourteen (14) doses ordered by the physician for Resident #24.

The surveyor reviewed Resident #24's clinical record on 5/11/17. Resident #24 was admitted to the facility 5/2/17 with diagnoses that included but not limited to cellulitis of left upper limb, insomnia, hypertension, anxiety, acquired hemolytic anemia, iron deficiency anemia, edema, acute kidney failure, liver disease, hyperlipidemia, depressive disorder, and type 2 diabetes mellitus.

Resident #24's admission minimum data set (MDS) had not been completed.

The signed admission physician orders dated 5/2/17 for Resident #24 included the order that read "6. Doxycycline 100 mg po (by mouth) bid (twice a day) x 7 days dx (diagnosis) cellulitis."

The May 2017 admission medication administration record was reviewed. Doxycycline 100 mg was entered and nurses had initialed administration of the drug beginning 5/2/17 at 5:00 p.m. through 5/9/17 5:00 p.m. for a total of

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The facility will follow physician orders for medication administration for resident #24 and all other residents identified in the deficient practice that follows.

A. For resident #24 all licensed nurses have been re-inserviced on following ABT physician orders. Count number of doses and number of meds. Other residents receiving ABT have been audited and are in compliance.

B. The facility has completed an audit by unit coordinators, MDS nurses, DON/DOPS to ensue deficient practice has not affected other residents. The physician for resident #24 has been notified and the resident was notified of med error.

C. All licensed nurses have been re-inserviced by the DON, unit coordinators with return demonstration on how to follow physician orders on dosing and blocking out days on the Medication Administration Record (MAR) record for those residents on ABT. This will be monitored by the DON, DOPS, unit coordinators, and supervisors.

D. To prevent reoccurrence the pharmacy consultants, DON, DOPS, unit coordinators and supervisors will be checking daily for continued compliance. This will be brought to the quarterly Q.A. Committee and reviewed with medical

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F 329	Continued From page 14 15 doses. Resident #24 received one extra dose of the Doxycycline. The surveyor interviewed the unit manager licensed practical nurse #2 on 5/11/17 at 8:05 a.m. The unit manager stated it looked like Resident #24 received one extra dose. The unit manager stated she would call the contracting pharmacy to check if a dose of the medication had been removed from the facility stat box. The unit manager was unable to locate any drug removal papers for the stat box in the facility. The surveyor requested a copy of the contents of the facility stat box from the director of nursing on 5/11/17 at 9:00 a.m. The surveyor reviewed the "Blue Ridge Box Listings" on 5/11/17. The list indicated there were 10 available doses of Doxycycline 100 mg. The surveyor interviewed the unit manager L.P.N. #2 again on 5/11/17 at 10:40 a.m. The unit manager stated when she contacted the pharmacy, the pharmacy informed her that one Doxycycline 100 mg came from the stat box for Resident #24 and stated "he got one too many." The surveyor informed the administrative staff of the issue with Resident #24's medication administration during a meeting on 5/11/17 at 11:00 a.m. No further information was provided prior to the exit conference on 5/11/17.	F 329	directors for continued compliance to prevent reoccurrence. The facility will be in substantial compliance by June 15, 2017.	
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2)	F 387		6/15/17

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F 387	Continued From page 15 (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure timely physician visits for 1 of 31 Residents in the sample survey, Resident #3. The Findings Included: Resident #3 was a 7 year old male who was originally admitted on 3/22/12 and readmitted on 6/30/16. Admitting diagnoses included, but not limited to: perforation of the intestine, dementia without behaviors, altered mental status, aphasia, vascular dementia, hypertension, diabetes mellitus and failure to thrive. The most current Minimum Data Set (MDS) located on the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/25/17. The facility staff coded that Resident #3 had short and long term memory loss (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff coded that Resident #3 required total nursing care (4/2) with ADL's. On May 10, 2017 at 8:15 a.m. the surveyor	F 387	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for Resident #3 and all other residents. A. Corrective action has been accomplished for resident #3 that was found to have been affected by the deficient practice as described in the following: 1. Resident #3□s physician has been notified of the deficient practice. Progress note is now up to date for resident #3. B. All clinical records have been reviewed by senior nursing staff, to identify other residents who have the potential to be affected by the same deficient practice. C. To ensure the deficient practice will not recur, audits will be done monthly by the medical records department for continued compliance. D. Senior nursing staff, MDS, unit coordinators, DON, will follow-up monthly	

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F 387	Continued From page 16 reviewed Resident #3's clinical record. Review of the clinical record produced physician progress notes dated 11/9/16 and 2/1/17. Review of the clinical record failed to produce evidence/documentation of a physician visit from 11/9/16 through 2/1/17. On May 10, 2017 at 9:15 a.m. the surveyor notified the Unit Manager (UM) who was a Licensed Practical Nurse (LPN #4), that Resident #3 did not have physician progress notes or evidence of being seen by the physician from 11/9/16 through 2/1/17. The surveyor and UM (LPN #4) reviewed Resident #3's clinical record. The surveyor specifically reviewed the physician progress notes dated 11/9/16 and 2/1/17 with the UM (LPN #4). The UM (LPN #4) reviewed Resident #3's clinical record and was unable to locate documentation/evidence that Resident #3 was seen between 11/9/16 and 2/1/17. On May 10, 2017 at 2:40 p.m. the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON), Director of Professional Services (DPS) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that review of Resident #3's clinical record failed to produce evidence/documentation that Resident #3 was seen by the physician from 11/9/16 through 2/1/17. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure timely physician visits for Resident #3.	F 387	from the medical records audit. Physicians found to be in non-compliance will be notified by the medical directors of the facility. The facility will be in substantial compliance by June 15, 2017.	
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1)	F 425		6/15/17

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F 425	Continued From page 17 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure that the pharmacist completed a monthly Drug Regime Review (DRR) for 1 of 31 Residents in the sample survey, Resident #3. The Findings Included: Resident #3 was a 7 year old male who was originally admitted on 3/22/12 and readmitted on 6/30/16. Admitting diagnoses included, but not limited to: perforation of the intestine, dementia without behaviors, altered mental status, aphasia, vascular dementia, hypertension, diabetes mellitus and failure to thrive. The most current Minimum Data Set (MDS) located on the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/25/17. The facility staff coded that Resident #3 had short and long term memory loss (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff coded that	F 425	The facility will provide pharmaceutical services to meet the needs of each resident, including Resident #3. A. Corrective action has been accomplished for Resident #3. Resident has been seen by pharmacy with no recommendations at this time. Audit conducted by senior nursing staff has been completed to ensure that other residents have not been affected by the delinquent practice. B. Senior facility administrative staff have met with senior pharmacy staff to implement a system to prevent deficient practice from reoccurring. C. Pharmacy will use a census sheet for each unit to ensure continued compliance. For residents that are moving from 2nd floor to 3rd floor or 1st floor, a notification sheet will e provided to the pharmacy staff.	

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F 425	Continued From page 18 Resident #3 required total nursing care (4/2) with ADL's. On May 10, 2017 at 8:15 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record failed to produce an April 2017 Drug Regime Review (DRR). On May 10, 2017 at 9:15 a.m. the surveyor notified the Unit Manager (UM) who was a Licensed Practical Nurse (LPN #4), that Resident #3 did not have a monthly DRR. The surveyor notified the UM (LPN #4) that Resident #3 did not have an April 2017 DRR. The surveyor and UM (LPN #4) reviewed Resident #3's clinical record. The surveyor reviewed the document titled, "Pharmacist Chart Review," with the UM (LPN #4). The surveyor pointed out that Resident #3 was missing an April 2017 pharmacy DRR. The UM (LPN #4) reviewed Resident #3's clinical record and was unable to locate and April 2017 DRR. On May 10, 2017 at 2:40 p.m. the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON), Director of Professional Services (DPS) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that review of Resident #3's clinical record failed to produce an April 2017 DRR. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the pharmacist completed a monthly DRR for Resident #3.	F 425	D. Continued compliance will be monitored by the DON, DOPS, and administrator weekly in the QA meeting. Pharmacy staff will review census sheet with DOPS before leaving facility for continued compliance. The facility will be in substantial compliance by June 15, 2017.	
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		6/15/17

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F 514	Continued From page 19 LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (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 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 and clinical record review, it was determined that the facility staff	F 514	The facility will provide complete and accurate clinical records for each resident,	

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failed to ensure a complete and accurate clinical record for 4 of 31 Residents in the sample survey, Resident #3, Resident #8, Resident #10 and Resident #14.

The Findings Included:

1. For Resident #3 the facility staff failed to accurately document his weights.

Resident #3 was a 7 year old male who was originally admitted on 3/22/12 and readmitted on 6/30/16. Admitting diagnoses included, but not limited to: perforation of the intestine, dementia without behaviors, altered mental status, aphasia, vascular dementia, hypertension, diabetes mellitus and failure to thrive.

The most current Minimum Data Set (MDS) located on the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/25/17. The facility staff coded that Resident #3 had short and long term memory loss (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff coded that Resident #3 required total nursing care (4/2) with ADL's.

On May 10, 2017 at 8:15 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced Resident #3's weights over the past year. The weights were documented as:

6/7/16 166.40
6/19/16 171.00
7/3/16 125.50
7/10/16 124.10

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including #3, #8, #10, and #14.

A. Corrective action has been accomplished for resident #3. A complete audit of all weights has been completed for resident #3 and all other residents to ensure continued compliance in accurate records. Resident #8 corrective action has been accomplished and the telephone order has been corrected. An audit of all telephone orders and P.O.S. have been completed on all residents by the 3rd shift nursing staff for continued compliance.

Corrective action has been accomplished for resident #10. Audits have been completed by the medical records department on resident #10 and all other residents to ensure continued compliance of resident medical records accuracy.

Corrective action for resident #14 has been accomplished. Please see Tag #F-329 for continued compliance, inservices and QA measures.

B. All resident clinical medical records will be audited monthly by senior nursing staff to identify other residents who have the potential to be affected in the same deficient practice.

1. Weights/accuracy #3
2. Telephone orders/accuracy #8
3. Resident medical records/accuracy #10
4. Medication doses/accuracy #14

C. All staff will be re-inserviced on

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7/17/16 126.30
7/24/16 165.80
7/25/16 161.90
8/1/16 161.60

On May 10, 2017 at 9:15 a.m. the surveyor notified the Unit Manager (UM) who was a Licensed Practical Nurse (LPN #4), that Resident #3's weight sheet documented that he lost about 50 pounds from 6/19/16 through 7/3/16 and then gained about 40 pounds from 7/17/16 through 7/24/16. The surveyor asked the UM (LPN #4) how was it possible for Resident #3 to lose and gain that much weight in such a short amount of time. The surveyor and UM (LPN #4) reviewed Resident #3's clinical record. The surveyor reviewed Resident #3's weights with the UM (LPN #4). The UM stated that the weights were inaccurate.

On May 10, 2017 at 2:40 p.m. the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON), Director of Professional Services (DPS) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that review of Resident #3's clinical record documented that he had lost about 50 pounds from 6/19/16 through 7/3/16 and then gained about 40 pounds from 7/17/16 through 7/24/16. The surveyor notified the Administration Team (AT) that Resident #3's weights were inaccurately documented as it was not possible to lose 50 pounds in approximately 2 weeks and then gain 40 pounds in one week.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record

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accurate and complete documentation in a resident□s clinical record. Examples of this issue will be cited during the training to ensure the medical records/nursing staff understands the importance of accurate documentation and this issue does not recur. The unit coordinators, DON/DOPS will monitor monthly.

D. The audits will be collected by the DON/DOPS monthly, and reported at the quarterly QA committee to prevent deficient practice does not recur.

The facility will be in substantial compliance by June 15, 2017.

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for Resident #3.

2. For Resident #8 the facility staff failed to document the correct date on a physician telephone order.

Resident #8 was a 96 year old female who was originally admitted on 11/15/16 and readmitted on 3/18/17. Admitting diagnoses included, but were not limited to: osteoarthritis, hypertension, acute kidney failure, major depression, anxiety, pseudobulbar affect, psychotic disorder with hallucinations and cataracts.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 4/13/17. The facility staff coded that Resident #8 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #8 required limited (2/2) to extensive assistance with Activities of Daily Living (ADL's).

On May 9, 2017 at 1:20 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced a physician telephone order dated 2/23/17 that ordered a CBC and CMP on Monday. The order had been originally identified the order date as 2/3/17 and had been scored through (marked through with a single line) indicating the wrong date had been originally written down incorrectly.

Continued review of the clinical record failed to produce the results of the CBC and CMP for 2/27/17 as the order was written to get the CBC and CMP on the Monday following the 2/23/17 date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	300 BLUE RIDGE STREET MARTINSVILLE, VA 24112

(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
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On May 9, 2017 at 2:05 p.m. the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN #1), that Resident #8 had a physician telephone order dated 2/23/17 to obtain a CBC and CMP on Monday (2/27/17.) The surveyor notified the UM (LPN #1) that review of the clinical record failed to produce the results for the physician ordered labs. The UM (LPN #1) reviewed the clinical record and could not locate the lab results for the CBC and MP for 2/27/17.

On May 10, 2017 at 10:30 a.m. the Director of Professional Services (DPS) approached the surveyor and informed the surveyor that the order date was incorrect on the physician telephone order. The DPS stated that the order date should have been 4/23/17, as the CBC and CMP were drawn on 4/24/17. The surveyor reviewed a calendar and 4/24/17 was on a Monday. The surveyor also observed the results of a CBC and CMP in the clinical record that had been obtained on 4/24/17. The DPS stated that the LPN who had written the order had documented the wrong date when she obtained the physician order.

On May 10, 2017 at 2:40 p.m. the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON), DPS and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that review of Resident #8's clinical record produced a physician telephone order dated 2/23/17 that ordered a CBC and CMP. The surveyor notified the AT that the LPN who obtained the physician order had written the incorrect on the physician telephone order.

No additional information was provided as to why

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the facility staff failed to ensure a complete and accurate clinical record for Resident #8.
3. The facility staff failed to ensure an accurate clinical record for Resident #10. Resident #10's clinical record contained medical information concerning two other residents in the facility.

The surveyor reviewed Resident #10's clinical record on 5/9/17 and 5/10/17. Resident #10 was admitted to the facility 10/26/12 and readmitted 3/2/17 with diagnoses that included but not limited to chronic inflammatory demyelinating polyneuritis, osteomyelitis, atrial fibrillation, hypertension, atherosclerotic heart disease, rheumatic disorders of the heart, convulsions, paraplegia, neuromuscular dysfunction of the bladder, anxiety, gastroparesis, delusional disorders, and type 2 diabetes mellitus.

Resident #10's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/9/17 assessed the resident with a cognitive summary score of 15.

During the record review, the surveyor located the February 2017 medication administration record (6 pages) for another facility resident in Resident #10's record and a psychology note dated 11/07/16 for another facility resident.

The surveyor interviewed the unit manager licensed practical nurse #4 on 5/10/17 at 10:50 a.m. The unit manager stated the unit secretary was no longer employed at the facility and stated the filing could have been done by an intern. The unit manager L.P.N. #2 removed the paperwork of the other residents from Resident #10's chart.

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F 514	Continued From page 25 The surveyor informed the administrative staff of the above issue with filing inaccuracy on 5/10/17 at 2:42 p.m. No further information was provided prior to the exit conference on 5/11/17. 4. The facility staff failed to ensure an accurate May 2017 medication administration record for Resident #14. The clinical record of Resident #14 was reviewed 5/9/17 and 5/10/17. Resident #14 was admitted to the facility 4/9/15 with diagnoses that included but not limited to pain, constipation, anxiety, hypertension, mood disorder, anxiety, non-traumatic subdural hemorrhage, atherosclerotic heart disease, hyperlipidemia, and spinal stenosis. Resident #14's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/28/17 assessed the resident with a cognitive summary score of 12. Resident #14 had an order dated 4/25/17 that read "Cipro 500 mg (milligrams) 1 tab (tablet) po (by mouth) q (every) 12 hrs (hours) for 7 days Dx: (diagnosis) UTI (urinary tract infection)." The surveyor reviewed the April 2017 medication administration record and the May 2017 medication administration record. The April 2017 MAR had documentation that Cipro was administered beginning 4/26/17 at 9A through 4/30/17 at 9P for a total of ten (10) doses. The May 2017 MAR had documentation that the resident received Cipro 5/1/17 beginning	F 514		

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at 9A through 5/2/17 9A for a total of five (5 doses). The total doses documented as administered were 15 doses; however, the amount ordered was fourteen (14) doses. There was one extra Cipro documented.

The surveyor requested the pharmacy manifest from the director of nursing on 5/9/17 at 3:05 p.m. and informed the DON of the concern with the documentation of administered medications.

The surveyor reviewed the pharmacy manifest on 5/10/17. Ciprofloxacin HCL 500 mg tab quantity of 14 was sent and the facility signed receipt of the medication on 4/26/17.

The surveyor informed the administrative staff of the medication documentation concern on Resident #14's May 2017 MAR on 5/10/17 at 2:42 p.m.

No further information was provided prior to the exit conference on 5/11/17.