PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION MORE OF PROVIDER OR SUPPLER PRANCIS MARION MANOR HEALTH & REHABILITATION MARION MANOR HEALTH & REHABILITATION MARION. VA. 24354 FEGULATORY OR LSC DEFINITION MAY BE PRECEDED BY PULL FACT DEFICIENCIES FREE CACHE DEFINITION MAY BY BE PRECEDED BY PULL FACT DEFICIENCIES FROM INITIAL COMMENTS An unamounced Medicare/Medicaid standard survey, was conducted 02/28/17 through 03/02/17. One complaint was investigated during the survey. Correct State required for complaince with 42 CFR Part 433 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents it through 23). F 164 483.10 (h)(f)(37), 483.70(f)(2) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(f) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3) The resident has the right to secure and confidential personal and medical records except as provided at \$483.70(f)(2) Personal and medical records except as provided at \$683.70(f)(2) or other applicable federal or state laws. S483.70 (f) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,			OWR NO. 0838	-0391
NAME OF PROVIDER OR SUPPLER FRANCIS MARION MANOR HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL FROM PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL FROM PRETX TAG PROVIDER STAND OF CORRECTION (EACH DEPROPRIATE OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL FROM PROPRIATE OF DEFICIENCY) FOOD INITIAL COMMENTS FOOD PROVIDER STAND OF CORRECTION (EACH DORRECTIVE ACTION SHOULD BE DEPROPRIATE OF DEFICIENCY) FOOD INITIAL COMMENTS FOOD	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '			COMPLETE	
FRANCIS MARION MANOR HEALTH & REHABILITATION 100 FRANCIS MARION MANOR HEALTH & REHABILITATION 101 PREPRIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG 102 PREPRIX TAG 103 INITIAL COMMENTS 103 INITIAL COMMENTS 104 PROPERTY TAG 105 INITIAL COMMENTS 105 INITIAL COMMENTS 106 INITIAL COMMENTS 107 INITIAL COMMENTS 108 INITIAL COMMENTS 109 INITIAL COMMENTS 109 INITIAL COMMENTS 100 INIT			495384	B. WING		·	į.	17
MARION, Va. 24354 MARION NATURE MARION MANOR HEALTH & REHABILITATION MARION, Va. 24354 PROPRIETE	NAME OF F	PROVIOER OR SUPPLIER		,	STREET	ADDRESS, CITY. STATE, ZIP CODE		
F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/28/17 through 03/02/17. One compliance with 42 CPR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 103 at the time of the survey. Corrections are required for compliance with 42 CPR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 1 through 23). F 164 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal cane, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records as years of the privacy pages when stepping away from her medicine cart to cover any resident information. 2. All residents have the potential to be affected by the same practice.	FRANCIS	S MARION MANOR H	EALTH & REHABILITATION				80	
An unannounced Medicare/Medicaid standard survey was conducted 02/28/17 through 03/02/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CRP part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 19 through 23). F 164 483.10(h)(1) (3)(i), 483.70(i)(2) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	° c	EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPI	OULD BE COMP	LETION
survey was conducted 02/28/17 through 03/02/17. One compliant 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 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 19 through 23). F 164 483.10(h)(13)(1): 483.70()(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 000	INITIAL COMMEN	TS	F 0	00			
103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 19 through 23). F 164 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL SEED PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. \$483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,		survey was conducted 03/02/17. One compliance with 42 Term Care requirer	cted 02/28/17 through plaint was investigated during ions are required for CFR Part 483 Federal Long ments. The Life Safety Code					
(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70 (i) Medical records. §483.70 (i) Medical records. §483.70 (i) Medical records. §483.70 (i) Medical records. §2017 (i) Medical records except as provided at laws. Share those served is important to the team at FMM 1. Immediate counseling was conducted with nurse to use the privacy pages when stepping away from her medicine cart to cover any resident information. 2. All residents have the potential to be affected by the same practice. Continued	F 164 SS≃D	The census in this 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 19 through 23). 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private			64	70.1	RECEN	Birm un
(h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,						those served is imported team at FMM 1. Immediate counsel conducted with nurse	VDH/OL to use the	017
of personal and medical records except as provided at \$483.70(i)(2) or other applicable federal or state laws. \$483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,						away from her medici	ne cart to	
(i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,		of personal and me provided at §483.70(i)(2) or oth	of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state			potential to be affected		
		(i) Medical records. (2) The facility mus	t keep confidential all					

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

AMAZINE FAMOLOGICAL AND AMAZINE TITLE

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.

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	49 LOK MEDICAKE	A MEDICAID SERVICES				<u> </u>
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		405004	B. WING			С
		495384	B. WING			03/02/2017
NAME OF I	PROVIOER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COOE	
FRANCIS	S MARION MANOR HI	EALTH & REHABILITATION) FRANCIS MARION LANE, PO BOX 880 ARION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	OBE COMPLÉTION
F 164	Continued From pa	ge 1	F 1	64	Continued	
	regardless of the fo	rm or storage method of the			Continued	
	records, except who	en release is-			2 37 1	. 1 .
	(i) To the individual,	or their resident			3. Nurses were re-educ	
		re permitted by applicable law;			use privacy covers duri	ng
	Topi coomanio mino	o pormitted by approache iden,			medication passes thro	agh 1:1
	(ii) Required by Law	<i>r</i> ,			sessions and will be rei	nforced
	• • • • • • • • • • • • • • • • • • • •				during Skills Fair April	12, 2017
		ayment, or health care			during bands and repris	12, 2017.
		litted by and in compliance			4 The DNI Norma Mana	~~~
	with 45 CFR 164.50	ю;			4. The RN Nurse Mana	-
	(iv) For public health	n activities, reporting of abuse,			(DON) or designee wil	
	• •	violence, health oversight			medication passes to m	onitor
		d administrative proceedings,			privacy 4 x weekly x 13	2 weeks
		rposes, organ donation			and monthly for six mo	onths.
		purposes, or to coroners,			Data will be reported to	
		funeral directors, and to avert			-	, the
		ealth or safety as permitted			QAPI team for further	
		e with 45 CFR 164.512.			interventions as determ	ined
	and the second s	IT is not met as evidenced			needed.	
	by:	on and staff interview the				
		protect private health care			Corrective action w	ill be
		24 Residents, Resident #10.			complete by 04/14/17.	
•	The findings include	d:				
	For Resident #10 the	e facility staff failed to				
		ication administration record				İ
		health care information while				<u> </u>
	staff was not in atter					
		dmitted to the facility on				ļ
		itted on 06/06/16. Diagnoses				
	included but not limit					
		artery disease, hypertension, disease, end stage renal				
	peripriera vaccuiar c	modado, ona diago foliai				1

disease, hyponatremia, anxiety, hypothyroidism,

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	10 1 OIL MEDIOMILE	G WEDICAID SERVICES			<u> </u>	MD 140. 0000-000 1		
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO		STRUCTION	(X3) OATE SURVEY COMPLETEO		
		405294	B. WING			C		
		495384	B. WING			03/02/2017		
NAME OF F	PROVIOER OR SUPPLIER			STREET	AOORESS, CITY, STATE, ZIP COOE			
FRANCIS	MARION MANOR H	EALTH & REHABILITATION			NCIS MARION LANE, PO BOX 880 N, VA 24354			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE COMPLETION		
F 164	Continued From pa	ge 2	F,	64				
	arthritis, depression							
The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/25 coded the Resident as 15 out of 15 in section cognitive patterns. This is an annual MDS.								
	On 03/01/17 at approximately 0830, the survey observed the medication cart setting outside of Resident #10's room. The nurse was not in attendance. The surveyor observed the medication administration book open on the ca with private health information for Resident #10 visible.							
	spoke with the DON asked what the prochealth information of stated that the nurse	roximately 0930, the surveyor I (director of nursing) and cedure was for protecting furing a med pass. The DON es have cover sheets to place dication administration record) a cart.						
					•			
	No further information was provided prior to exit. 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.		F 2	41	F241 Maintaining dignity of reducing dressing above as	esidents		
					during dressing changes important to the team at	FMM		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 3 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CO	INSTRUCTION	` ′сом	E SURVEY IPLETED
		405294	B. WING			ı	C 03/3047
		495384	D. WING		ET ADDRESS, CITY, STATE, ZIP CODE		02/2017
	PROVIDER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		100 Fi	RANCIS MARION LANE, PO BOX 8 ION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	by: Based on observat document review ar determined the faci maintain/enhance to (Resident #3) during Findings: Facility staff failed to Resident #3 during The surveyor review record on 3/1/17 an admitted to the facil that included but no pressure, decubitus adult failure to thrive Resident #3's curre assessment with ar (ARD) of 2/6/17 ass cognitive summary the resident to requidally living. Resident #3's curre	ion, staff interview, facility and clinical record review it was lity staff failed he dignity of 1 of 17 residents g a dressing change. o maintain and the dignity of a dressing change procedure. wed Resident #3's clinical and 3/2/17. Resident #3 was lity 10/5/16, with diagnoses of limited to anemia, high blood is ulcer, hypothyroidism, and e. nl minimum data set (MDS) in assessment reference date sessed the resident with a score of 99. Section G coded ire assistance with activities of		241	Continued 1. Education provided team member regarding appropriate labeling of and was documented in education file. 2. All residents have the potential to be affected same practice. 3. Policy will be clariff March 31, 2017 and edeprovided to other team regarding appropriate ledressings by April 12, 2017. 4. The RN Nurse Mana (DON) or designee will dressing changes for applabeling techniques 3 x applications.	dressings a her he by the hed by ucation members abeling of 2017.	ſ
	dated 1/13/17, identified the resident had a potential for skin impairment and pressure. On 3/1/17 at 2:15 p.m. a member of the survey team observed the wound care nurse change the dressing covering Resident #3's wounds. The nurse performed the dressing change per the current physician's order. The nurse then dated an alleyyn dressing and placed it on the coccyx			5. Corrective action will be complete by 04/14/17.			

FORM CMS-2567(02-99) Previous Versions Obsolete

area wound, her next step was to place an allevyn dressing on the hip wound, however, she

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 4 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	CO I OIL MEDIONICE	WINEDIGHT DERVIOLE				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING			C 03/ 02/2017
			١	etpcc:	TADDRESS, CITY, STATE, ZIP CODE	03/02/2017
NAME OF F	PRDVIDER OR SUPPLIER				•	
ERANCIS	MARION MANOR HI	EALTH & REHABILITATION			ANCIS MARION LANE, PO BOX 880	
MAROIC				MARIO	ON, VA 24354	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 241	the resident's hip. The surveyor inform	after placing the allevyn on	F 2	241		
	other administrative staff of the wound care issue during the end of the day meeting on 3/1/17 at 5:10 p.m. The surveyor requested the facility policy on handwashing/wound care. The surveyor informed the administrator and other administrative staff of the dignity issue during the end of the day meeting on 3/1/17 at 5:10 p.m.					
F 252 SS=D	No further information was provided prior to the exit conference on 3/2/17. 483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT		F 252		F252 Maintaining a clean, sanit homelike environment is important to the team at F	
	(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.				1. On 3/1/17 the EVS tea cleaned both resident room identified as needing atternal.	ns
	§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-				2. All residents have the potential to be affected by same practice.	the
	environment, allowing	comfortable, and homelike ng the resident to use his or gings to the extent possible.			Со	ntinued
		suring that the resident can rvices safely and that the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 5 of 67

RECEIVED

MAR 3 0 2017

VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-039					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		CONSTRUCTION	(X3) DATI	E SURVEY IPLETED	
		495384	B. WING	;		ľ	C '02/2017	
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
TO A NICH	C STADION MANOD U	TAITU O DELLA DILITATIONI		100	FRANCIS MARION LANE, PO BOX 880			
FRANCIS	3 MARION MANOR III	EALTH & REHABILITATION	:	MAF	RION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	IXSI COMPLETION DATE	
F 252	Continued From page 5 physical layout of the facility maximizes resident independence and does not pose a safety risk.			F 252 Continued			,	
	(ii) The facility shall the protection of the or theft. This REQUIREMENT by: Based on observatinterview, facility do record review, the facilean, sanitary, hor residents (Resident The findings included 1. The facility staff room was clean and Resident #7 was ad and readmitted 2/22 included but not limit gastritis, esophagitis hernia, hypertension pulmonary disease, failure, chronic kidnehypothyroidism, sev dementia with delus diabetes mellitus, at coronary artery dise	exercise reasonable care for a resident's property from loss NT is not met as evidenced tion, resident interview, staff ocument review, and clinical acility staff failed to ensure a nelike environment for 2 of 24 t #7 and Resident #8). ed: failed to ensure Resident #7's d sanitary and without odor. dmitted to the facility 9/10/14 2/17 with diagnoses that ited to ischemic colitis, s, duodenal ulcer, hiatal n, chronic obstructive chronic hypoxic respiratory ey disease stage 4, vere dysmobility, vascular sions, major depression, trial fibrillation, schizophrenia,			 3. EVS team members were educated regarding proper cleaning techniques on 3/1/Cycle room cleaning will be in April identifying 3-5 room weekly. 4. Audits will be conducted the EVS Manager 10 x week 12 weeks and 10 monthly formonths. Data will be report the QAPI team. 5. Corrective action will be complete by 04/14/17. 	/17. pegin oms I by ekly x for 6 ted to		
	assessment with an (ARD) of 9/11/16 co	al minimum data set (MDS) assessment reference date ded the resident with a score of 00 out of 15 in						

FORM CMS-2567(02-99) Previous Versions Obsolele

Section C Cognitive Patterns.

Even[ID:4K7211

Facility ID: VA0086

If continuation sheet Page 6 of 67

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	E & MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·	OMB NO	<u>). 0938-0391</u>				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOII		CONSTRUCTION		(X3) OATE SURVEY COMPLETEO C 03/02/2017	
		495384	B. WING_	·		03		
	PROVIDER OR SUPPLIER S MARION MANOR H	EALTH & REHABILITATION	:	100	EET AOORESS, CITY, STATE, ZIP COOE FRANCIS MARION LANE, PO BOX 8 RION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI OEFICIENCY)	OULO BE	COMPLETION DATE	
F 252	Continued From page	age 6	F 25	52	*	"		
	The surveyor obset 12:20 p.m. Reside with the head of the by staff. The surve the room noticeable and the roommate have an indwelling fall mat on the floor roommate. A dried inches in diameter	rved Resident #7 on 2/28/17 at ent #7 was positioned in bed e bed elevated and being fed eyor smelled an odor of urine in e between Resident #7's bed. Resident #7 was noted to Foley catheter. There was a r between Resident #7 and the I yellow area approximately 3 was noted on the left side of					A Comment of the Comm	
	drainage bag. The surveyor obse 3/1/17 at 8:05 a.m. surveyor smelled the surveyor located the nurse and asked if	rved Resident #7 again on Resident #7 was in bed. The ne urine odor again. The e quality assurance registered she smelled odors in Resident stated she agreed there was a om.						
		ned the administrative staff of on 3/1/17 at 5:10 p.m.		:				
- - - - -	(environmental ser 3/2/17 at 8:08 a.m.	wed the job title for EVS vices) tech (technician) on Part of the job title read "Daily . Dust mop and wet mop		:		•		
	floors was listed as cleaning. The job t read "High Profile C Cleaning included" staff provided the s	part of the daily entrance itle also had a section that Cleaning". High Profile 9. Damp mop." The facility urveyor with the "10 Step on 3/2/17. Position 9. Read to		*	- -		the first train is a set that it is compared to	
	No further informate exit conference on	on was provided prior to the 3/2/17.						

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	C FOR MEDICARE	9 MEDICAID SEDVICES			• .	O!	MR NO	0938-0391
	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X3) WIT	TIPI E C	ONSTRUCTION			SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	1 '					PLETED
			ı					C
	<u></u>	495384	B. WING				03/	02/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZI			
FRANCIS	MARION MANOR HE	EALTH & REHABILITATION	l		FRANCIS MARION LANE, PO) BOX 880		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				MAH	RION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 252	Continued From pa	ge 7	F 2	52				
	=	failed to ensure a clean and						
		nvironment for Resident #8.						
	·	had a urine odor and						
	multiple black scult	marks at the foot of the bed.						
	Resident #8 was ac	lmitted to the facility on						
		tted on 10/02/16. Diagnoses						
		ited to anemia, anxiety,						
	pressure ulcer.	ia, urinary tract infection and						
		DS with an ARD (assessment						
		1/10/17 coded the resident as ion C, Cognitive Patterns.						
	10 out 51 10 111 0001							
		ved Resident #8 during the			•			,
		7 beginning at 10:35 a.m. bed and noted to have a						
		odor of urine was noticeable						
	in the room.							
	A second surveyor	observed Resident #8 on						
		nes during the day and once						
		ne odor in the room.						
	The first supremer of	bserved Resident #8 again on						
		The urine odor was not as						
	noticeable but at the	e foot of the resident's bed,						
		ed multiple black, scuffed						
		und the left wheel and ately 10-12 inches in all	-					
		veyor interviewed the						
	environmental servi	ces technician (other #5) on					٠.	1
	3/1/17 at 4:00 p.m.	She was asked about her						
		nmental services technician.						
		er job was to mop the floors. 't mop every day. The						ŀ
	OHE SIGNO SHE UIUH	chinop overy day. The						I

FORM CMS-2567(02-99) Previous Versions Obsolete

environmental services technician was asked about the black scuff areas. She stated they

Event ID:4K7211

Facility ID: VA0086

If continuation sheet Page 8 of 67

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

OLIVILI	10 1 OIL MEDIOMILE	L & MILDIONID OF WOL			MD MO. 0330-033
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING		C 03/02/2017
	PROVIDER OR SUPPLIER	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	03/02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 272 SS=E	She stated she had wheel to be checke area. The surveyor inform the odor in the room on the floor of Resid 5:10 p.m. The surveyor review on 3/2/17 at 8:08 a. "Daily Entrance Clemop floors was listed cleaning. The job tiread "High Profile Colleaning included "Staff provided the statement of Cleaning Process" of "damp mop." No further information exit conference on 3/483.20(b)(1) COMP ASSESSMENTS (b) Comprehensive of the statement of the stat	e rubber coming off the wheel. It put a work order in for the ed but had not cleaned the med the administrative staff of m and the black scuffed areas ident #8's room on 3/1/17 at wed the job title for EVS tech m. Part of the job title read eaning". Dust mop and wet ed as part of the daily entrance itle also had a section that cleaning". High Profile '9, Damp mop." The facility urveyor with the "10 Step on 3/2/17. Position 9. Read to ion was provided prior to the 3/2/17.	F 272	F272	ant to l and it f care
	assessment must in			documentation on the CAA worksheet for Residents #2 #14 or #7.	
				4 5	,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility IO: VA0086

If continuation sheet Page 9 of 67

RECEIVED

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
					C	
		495384	B. WING		03/02/2017	
	PROVIDER OR SUPPLIER S MARION MANOR H	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION	
F 2 7 2	Continued From pa (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v	n. avior patterns. vell-being.	F 2	272 Continued		
	(viii) Physical fu problems. (ix) Continence. (x) Disease diagnot (xi) Dental and nutron (xii) Skin Conditions (xiii) Activity purson (xv) Special treatmet (xvi) Discharge (xvii) Documental regarding the addition the care area of the Minimum Daton (xviii) Documental assessment. The alinclude direct observation the resident, as wellicensed and	esis and health conditions. itional status. s. suit. s. ents and procedures. clanning. ition of summary information onal assessment performed s triggered by the completion		 All residents have the potential to be affected by same practice. MDS team members we educated regarding proper completion of Section V o MDS. A check sheet was developed for team members use to assist in making surrequirements are addressed. The RN Nurse Manager (DON) will audit the work weekly for 12 weeks and the CAA worksheet 4 x months 6 months. Data will be repto the QAPI team. 	ere re- f the ers to e l. sheet ne ly for	
	observation and cor as well as communi non-licensed direct shifts. This REQUIREMEN by: Based on staff inter review, the facility st complete Section V	ocess must include direct mmunication with the resident, cation with licensed and care staff members on all IT is not met as evidenced eview and clinical record raff failed to accurately of the MDS (Minimum Data dents in the survey sample		5. Corrective action will be complete by 04/14/17.		

PR(NTED: 03/22/2017 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB	NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3	(X3) DATE SURVEY COMPLETED	
		•				С	
		495384	B, WING		<u>- </u>	03/02/2017	
	PROVIDER OR SUPPLIER MAR(ON MANOR H	EALTH & REHAB(L(TAT(ON		STREET ADDRESS, CITY, STA 100 FRANCIS MARION LAN MAR(ON, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIAT LENCY)		
F 272	Continued From pa (Resident #2, #4, #		F 2	72			
	The findings include	ed:					
	dates and/or location documentation countinical record for Sassessment (CAA) Data Set (MDS). Resident #2 was ac 2/27/16 with the following the failure, diabetes, and chronic obstructive hyponatremia and has coded on the Man ARD (Assessment tool us possible score of 1 coded as supervision documents).	aff failed to document the ons for where the Id be found in Resident #2's ection V of the Care Area Summary of the Minimum Idmitted to the facility on owing diagnoses of, but not high blood pressure, heart exiety disorder, depression, pulmonary disease, hyperkalemia. The resident MDS (Minimum Data Set) with ent Reference Date) of 2/27/17 Interview for Mental Status, an ed) with a score of 14 out of a 5. Resident #2 was also on of 1 staff member for ing limited assistance with					
	of Resident #2's ch noted that on the M Section V of the CA locations of the doc triggered area were ADL (Activities of D the "Nature of the p Functional the follow documented: "	acted a clinical record review art on 3/1/17. The surveyor DS with an ARD of 2/27/17 in A Summary the dates and cumentation to support the not properly documented for aily Living) Functional. Under problem/condition" for ADL wing was noted to be (name of resident) has ADL) impaired mobility, lack of chronic obstructive pulmonary gested heart failure), Anxiety,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 11 of 67

RECEIVED MAR 3 0 2017

ADHIOFC

PRINTED: 03/22/2017 FORM APPROVED

	INCINI OF THE RETAIL					OMEN	O 0020 0204
CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					·	<u>IO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		OATE SURVEY OMPLETED
		495384	B. WING	i		,	C 03/02/2017
NAME OF I	PROVIDER OR SUPPLIER	1	3	STR	REET ADDRESS, CITY, STATE, ZIP (
				100	FRANCIS MARION LANE, PO E	3OX 880	
FRANCIS	5 MARION MANUK HI	EALTH & REHABILITATION		MA	RION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5] COMPLETION OATE
F 272	Continued From pa	aae 1 1	F:	272			
-	=	ia, Agitation. She refuses at					
		days to allow staff to bath and					
	The MDS nurse #1 documented finding approximately 2 pm put where I get the interview. I don't kr way. We have bee since August. I hav support to speak to						
	documented finding	team wa s notified of the above gs in the end of the day 17 at approximately 5:20 pm					
		ion was provided to the e exit conference on 3/2/17.					
	dates and/or location documentation coul clinical record for S	taff failed to document the ons for where the lid be found in Resident #4's tection V of the Care Area Summary of the Minimum					
	3/14/16 with the foll limited to anemia, a disease, high blood dementia, and hepathange MDS (Minin (Assessment Referresident was coded)	dmitted to the facility on lowing diagnoses of, but not atrial fibrillation, coronary heart of pressure, diabetes, stroke, atic failure. On the significant mum Data Set) with an ARD rence Date) of 12/19/16, the dias having a BIMS (Brief I Status, an assessment					

FORM CMS-2567(02-99) Previous Versions Obsolete

protocol) of 00 out of a possible score of 15. Resident #4 was also coded as being totally

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet and ED

PRINTED: 03/22/2017 FORM APPROVED

		O MAEDICAID CEDVICES			_	,	. 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COV	E SURVEY IPLETED
		495384	B. WING			ł.	C / 02/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		PACTUR DELIADU ITATION		10	0 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARIUN MANUR HI	EALTH & REHABILITATION	-	M	ARION, VA 24354		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 2 7 2	Continued From pa	age 12	F 2	72			
,	dependent on 2 sta	aff members for dressing,					
	personal hygiene a	nd bathing.					
	The surveyor condu	ucted a clinical record review					
	of Resident #4's ch	eart on 3/1/17. The surveyor					
	noted that on the M	IDS with an ARD of 12/19/16 in AA Summary the locations of					
	the dates and/or do	ocumentation to support the					
	following triggered	area were not properly			·		
	documented for: Ur	rinary Incontinence and					
	Indwelling Catheter	and Pressure Ulcer.			÷		
	The MDS nurse #1	was notified of the above					
	documented finding	gs by the surveyor on 3/1/17 at					
ŀ	approximately 2 pm	n. The MDS nurse #1 stated "I					
	put where I get the	information like if it was in an now why this was done this					
	way We have bee	now why this was done this en using this computer system					
	since August, I hav	ve put in a call to the computer			·		
	support to speak to	the MDS specialist there."					
	The administrative	team was notified of the above					
	documented finding	gs in the end of the day					
		17 at approximately 5:20 pm					
	by the surveyor.						
	No further informat	ion was provided to the					
	surveyor prior to the	e exit conference on 3/2/17.					
	3. The facility s	staff failed to document the					
	dates and/or location	ons for where the					
	documentation cou	ald be found in Resident #14's					
	clinical record for S	Section V of the Care Area Summary of the Minimum					
	Data Set (MDS).	Canninary of the Minning.					
l	244 001 (18120).						

PRINTED: 03/22/2017

F272 Continued From page 13 dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.	D-1741	inierit of the init	, to					MIAPPROVED
A. BUILOING A. BUILOING A. BUILOING B. WING STREET AOORESS, CITY. STATE, ZIP CODE 100 FRANCIS MARION MANOR HEALTH & REHABILITATION CX41 IO PREFIX (EACH OEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE OAT	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>ЭМВ NO</u>	<u>). 0938-0391</u>
NAME OF PROVIOER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION (X4) IO PREFIX TAG (EACH OFFICIENCY MUST BE PRECEOGE OB Y FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OAT OFFICIENCY) F 272 Continued From page 13 dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.				1				MPLETEO
FRANCIS MARION MANOR HEALTH & REHABILITATION 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354 (X4) IO PREFIX (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION) F 272 Continued From page 13 dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.			495384	B. WING	i		0:	-
X4 10 SUMMARY STATEMENT OF OFFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OFFICIENCY	NAME OF	PROVIOER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COOE		
F 272 Continued From page 13 dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.	FRANCIS	S MARION MANOR HI	EALTH & REHABILITATION		!		,	
dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.	PREFIX	(EACH OEFICIENCY	MUST BE PRECEOEO BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO	O BE	(X5) COMPLETION OATE
The surveyor conducted a clinical record review of Resident #14's chart on 3/2/17. The surveyor noted that on the MDS with an ARD of 12/19/16 in Section V of the CAA Summary the locations of the dates and/or documentation to support the following triggered area were not properly documented for: Communication, Psychosocial Well-Being, Mood State, Falls, Dehydration/Fluid Maintenance and Pressure Ulcer. The MDS nurse #1 was notified of the above documented findings by the surveyor on 3/2/17 at approximately 12:00 pm. The MDS nurse #1 stated "I put where I get the information like if it was in an interview. I don't know why this was done this way. We have been using this computer system since August. I have put in a call to the computer support to speak to the MDS specialist there." The administrative team was notified of the above documented findings in the end of the day conference on 3/2/17 at approximately 12:20 pm by the surveyor.	F 272	dementia, constipated generalized weakned (Minimum Data Set Reference Date) of coded as having a law Mental Status, an a of a possible score coded as requiring member for eating a being totally dependent bathing. The surveyor conductor of Resident #14's conted that on the M Section V of the CA the dates and/or dot following triggered a documented for: Co Well-Being, Mood S Maintenance and Proposition of the West of the CA the dates and the computer system sing approximately 12:00 stated "I put where I was in an interview. done this way. We computer system sing call to the computer specialist there." The administrative to documented finding conference on 3/2/1	tion, dysphagia and ess. On the admission MDS on the admission MDS on with an ARD (Assessment 11/15/16, the resident was BIMS (Brief Interview for sessment protocol) of 00 out of 15. Resident #14 was also extensive assistance of 1 staff and personal hygiene and dent on 2 staff members for acted a clinical record review that on 3/2/17. The surveyor DS with an ARD of 12/19/16 in A Summary the locations of cumentation to support the area were not properly mmunication, Psychosocial state, Falls, Dehydration/Fluid ressure Ulcer. Was notified of the above is by the surveyor on 3/2/17 at 0 pm. The MDS nurse #1 get the information like if it 1 don't know why this was have been using this nice August. I have put in a support to speak to the MDS eam was notified of the above in the end of the day	F	?72			

FORM CMS-2567(02-99) Previous Versions Obsolete

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

Event IO:4K7211

Facility ID: VA0086

If continuation sheet Page 14 of 67

RECEIVED MAR 3 0 2017 VDH/OLG

PRINTED: 03/22/2017 FORM APPROVED

	OF TOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			COMPLETED
						C
		495384	B, WING		ASST ADDRESS OF VICTOR AND CODE	03/02/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE FRANCIS MARION LANE, PO BOX 880	
FRANCIS	MARION MANOR HI	EALTH & REHABILITATION			RION, VA 24354	
	STAMMADY	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE COMPLETION RIATE DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)				DEFICIENCY)	
F 272	Continued From pa	ige 14	F	272		
		failed to ensure a complete				
	and comprehensive				•	
	Assessment) for Re	led to document the date of the	į			
•	documentation des	cribing Resident #7's clinical				
		mpacting care planning				
	(CAA) Summary.	on V-Care Area Assessment				
		dmitted to the facility 9/10/14				
		2/17 with diagnoses that nited to ischemic colitis,				
	gastritis, esophagiti	is, duodenal ulcer, hiatal				
	hernia, hypertensio	n, chronic obstructive				:
	pulmonary disease,	, chronic hypoxic respiratory ney disease stage 4,				
	hypothyroidism, sev	vere dysmobility, vascular				
	dementia with delus	sions, major depression,				
	diabetes mellitus, a coronary artery dise	strial fibrillation, schizophrenia,				
	hynerlipidemia dial	betic foot ulcer, and history of				
	stroke.					
	D - 1-1	ol minimum data aat (MDC)				
	assessment with an	al minimum data set (MDS) n assessment reference date				
	(ARD) of 9/11/16 cd	oded the resident with a				
	cognitive summary	score of 00 out of 15 in				
	Section C Cognitive	e Patterns. Section V CAA sident #7 had care areas				
		ecision to care plan the				
		loss/dementia, visual				
		cation, urinary incontinence eter, psychosocial well-being,				
	and indwelling cause	itional status, dehydration/fluid				
	maintenance, denta	al care, pressure ulcer,				
		use, and pain. The last column				
	titled "Location and	Date of CAA documentation"				

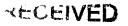
FORM CMS-2567(02-99) Previous Versions Obsolete

had "CAA WS (worksheet) dated 9/12/16 except for urinary and that section read "CAA WS dated

Event ID: 4K7211

Facility ID; VA0086

If continuation sheet Page 15 of 67



MAR 30 2017

PR(NTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE	
		495384	B. WING			03/0:	2/2017
•	PROVIDER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		100	REET AODRESS, CITY, STATE, ZIP COOE FRANCIS MARION LANE, PO BOX 880 RION, VA 24354		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)) BE	(X5) COMPLETION OATE
F 272	O8/11/2016." The surveyor review cognitive loss/demered "difficult in uncto) hearing impairm impaired". There we location documents area. The CAA workshee documentation that antidepressant/antiper dx. (diagnosis) seedlusions adm dx. Ohe communication read "difficulty finish impairment 09/09/1 assistive devices at no specific areas we found. The psychosocial Celedid have a statement from resident during Activities worksheet "Information obtained 09/09/16." Falls worksheet dat	ved the CAA worksheets. The entia worksheet dated 9/12/16 lerstanding others r/t (related ent, hearing and vision highly ere no specific dates or d to support the triggered t dated 9/12/16 for vision had read "Receives osychotic meds (medications) echizophrenia/dementia with	F 2	72			
	(related to) blindnes	s and hearing loss 09/09/16." nt information from 2016 as to					

FORM CMS-2567(02-99) Previous Versions Obsolete

located.

surrounding Resident #7's fall history could be

Event 10; 4K7211

Facility IO: VA0086

If continuation sheet Page 16 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) OATE SURVEY COMPLETEO
		495384	B. WING		C 03/02/2017
NAME OF F	ROVIOER OR SUPPLIER		···	STREET AOORESS, CITY, STATE, ZIP COOE	
				100 FRANCIS MARION LANE, PO BOX 880	
FRANCIS	MARION MANOR HI	EALTH & REHABILITATION		MARION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	O BE COMPLETION
F 272	Continued From pa	ge 16	F 2	72	
	"blindness per d/c s time, day, year and 09/09/16, difficulty the hearing loss 09/09/ documentation as to information was loc Dehydration CAA w	o the location of where the ated. orksheet dated 9/12/16 read			
	"Diabetic left lateral foot ulcer 0.6 x 0.4 wound care committee notes 09/08/16." Dental CAA worksheet dated 9/12/16 read "R/T (related to) hearing loss 09/09/16." Pressure Ulcer CAA worksheet dated 9/12/16 did have a note that read "left lateral foot diabetic ulcer 0.6 x 0.4 improving per wound care committee notes 09/08/16, diabetic foot ulcer on low airloss/alternating pressure mattress."				
	9/12/16 read "Adm receives above med schizophrenia/depredelusions." No spelocation where the in Pain CCA workshee "Resident unable to her pain on 09/09/14 dates concerning the interventions impler	Use CAA worksheet dated (admission) dx (diagnosis): dication for dx: ession/anxiety/dementia with cific admission dates or information was found. et dated 9/12/16 read answer questions regarding 6." There was no location or ite resident's pain location, mented, pain medications in-verbal assessments, etc.			
		iewed minimum data set urse #2 on 2/28/17 at 5:00			

FORM CMS-2567(02-99) Previous Versions Obsolete

p.m. MDS RN #2 reviewed the CAA worksheets and stated they were a work in progress. The

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 17 of 67

MAR 3 0 2017

ADH/OFC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u></u>	1
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	•	DINSTRUCTION	(X3) OATE SURVEY COMPLETEO
						С
		495384	B. WING			03/02/2017
NAME OF P	PROVIOER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP COOE	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION			RANCIS MARION LANE, PO BOX 880 ION, VA 24354	
(X4) IO PREFIX TAG	(EACH OFFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLETION
F 272	Continued From pa MDS RN #2 stated specific places and	the work sheets needed more	F2	272		
·	The surveyor inform	ned the administrative staff of on 3/2/17 at 12:20 p.m.				
	exit conference on			1		
F 278 SS=D	483.20(g)-(j) ASSE ACCURACY/COO	SSMENT RDINATION/CERTIFIED	F2	278	F278 Completing an accurate	MDS for
	(g) Accuracy of Ass must accurately ref	sessments. The assessment lect the resident's status.			all residents is a priority team at FMM	for the
	(h) Coordination A registered nurse each assessment of participation of hea	must conduct or coordinate with the appropriate lth professionals.			 MDS modifications v completed for both resident and #9 to reflect accurate 	lent #8
	(i) Certification (1) A registered number assessment is	rse must sign and certify that completed.			These were completed d survey and provided to t survey team.	
	(2) Each individual assessment must set that portion of the a	who completes a portion of the sign and certify the accuracy of assessment.			2. All residents have the potential to be affected became practice.	
	who willfully and kr	e and Medicaid, an individual nowingly-			3. MDS team members educated regarding prop of the MDS.	
	resident assessme	rial and false statement in a ent is subject to a civil money e than \$1,000 for each				Continued
	(ii) Causes another	individual to certify a material				:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 18 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	<u>. 0938-0391</u>
STATEMENT		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	СОМ	E SURVEY MPLETEO
		495384	B, WING			1	C / 02/2017
NAME OF F	PROVIDER OR SUPPLIER				REET AOORESS, CITY, STATE, ZIP COOE		
	- MANOR II	- * TO • DEDARM ITATION		100	FRANCIS MARION LANE, PO BOX 880		
FKANCIS	3 MARIUN MANUR III	EALTH & REHABILITATION		MA	RION, VA 24354		<u> </u>
(X4) IO PREFIX TAG	(EACH OFFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE	(X5) COMPLETION DATE
F 278		age 18 It in a resident assessment is oney penalty or not more than	F 2	.78	Continued		
	\$5,000 for each ass (2) Clinical disagree material and false s This REQUIREMEN by: Based on observation record review the false accurate MDS (minimum).	sessment. ement does not constitute a			4. The RN Nurse Manager (DON) or designee will aucompleted MDS 3 x weekl weeks and 5 x monthly x 6 months. Data will be report the QAPI team.	dit ly x 12 trted to	
	The findings include	ed:			5. Corrective action will be complete by 04/14/17.	е	
	For Resident #8, coded the Resident level.	the facility staff incorrectly t's upper extremity impairment					
	05/27/16 and readmincluded but not limit	dmitted to the facility on mitted on10/02/16. Diagnoses lited to anemia, anxiety, hia, urinary tract infection and					
·	reference date) of 0 as 15 out of 15 in se Section G, function functional limitation Resident as having or lower extremities most recent compredate of 06/03/16 cool	DS with an ARD (assessment D2/10/17 coded the Resident ection C, cognitive patterns status, subsection G0400, in range of motion coded the no impairment to either upper s. This is a quarterly MDS. The ehensive MDS with an ARD ded the Resident as having er extremity impairment in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Surveyor observed Resident #8 on 03/01/17 at approximately 0850. Resident was noted to have

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 19 of 67

RECEIVED

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					(0.0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
7.1.5 (2) 1.0		495384	A. BUILDI		·	0	C 3/ 02/2017
NAME OF F	PROVIDER OR SUPPLIER	100007	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/02/2017
				1	100 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR H	EALTH & REHABILITATION	1	ľ	MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 278	Continued From pa	ge 19	F 2	278	3	•	
	a contracture to left upper extremity, with decreased mobility and range of motion. The discrepancy in the coding of the Resident's range of motion was discussed with the administrative team during a meeting on 03/01/17 at approximately 1710.						
	The MDS coordinator provided the surveyor with a corrected MDS on 03/02/17 at approximately 0755.						
	No further informati	on was provided prior to exit.					
		the facility staff incorrectly ent's height on the MDS.					
	09/01/16. Diagnose	Imitted to the facility on s included but not limited to tes mellitus, dementia, and					
	coded the Resident cognitive patterns. S recorded the Resident is a quarterly MDS. comprehensive MD	OS with an ARD of 02/20/17 as 0 out of 15 in section C, Section K, subsection 0K0200 ent's height as 62 inches. This The most recent S recorded the Resident's in subsection 0K0200.					
	The discrepancy in height was discusse team during a meet approximately 1710	•					

FORM CMS-2567[02-99) Previous Versions Obsolete

0755.

The MDS coordinator provided the surveyor with a corrected MDS on 03/02/17 at approximately

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 20 of 67

RECEIVED MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO
					·	С
		495384	B. WING			03/02/2017
	PROVIDER OR SUPPLIER S MARION MANOR H	EALTH & REHABILITATION		100 FF	ET AOORESS, CITY, STATE, ZIP COOE RANCIS MARION LANE, PO BOX 880 ION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPE OEFICIENCY)	BE COMPLETION
F 2 7 8	Continued From pa	age 20	F 2	2 7 8		
SS=D	483.10(c)(2)(i-ii,iv,v PARTICIPATE PLA 483.10 (c)(2) The right to pand implementation plan of care, includ. (i) The right to participate included in the prequest meetings a revisions to the persected goals and amount, frequency, other factors related plan of care. (iv) The right to receipt included in the plan (v) The right to see right to sign after sign of care. (c)(3) The facility shright to participate in shall support the resplanning process must be a sign of care.	the care plan, including the gnificant changes to the plan all inform the resident of the his or her treatment and cident in this right. The ust—	F 2	280	F280 Updating care plans for a residents is a priority for at FMM 1. Resident #12's care plupdated to resolve risk for elopement. Resident #13 plan was updated to reflect MRSA and isolation. Copthe updates were given to survey team during the survey team during the survey team during the survey team for a survey team to be affected by same practice. 3. Re-educated team to up the care plan. Nurse who the order is responsible for updating the care plan. We reinforce education during Skills Fair April 12.	an was r 's care ct pies of the rvey. the date notes r
	(ii) Include an asses	sment of the resident's				

FORM CMS-2567(02-99) Previous Versions Obsolele

Eveni IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 21 of 67

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495384	B. WING			C
NAME OF	PROVIOER OR SUPPLIER	+83304	D. 11110	,	EET AOORESS, CITY, STATE, ZIP COOE	03/02/2017
		EALTH & REHABILITATION		1001	FRANCIS MARION LANE, PO BOX 880 RION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPE OEFICIENCY)	BE COMPLETION
F 280	Continued From pagestrengths and needs		F	280	Continued	
٠ - يد	cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive at (ii) Prepared by an irrincludes but is not lin (A) The attending phase (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of footo (E) To the extent prather resident and the An explanation must medical record if the and their resident region to practicable for the resident's care plan. (F) Other appropriate	7 days after completion of assessment. Interdisciplinary team, that mited to— Dysician. It is with responsibility for the are ponsibility for the and nutrition services staff. Interdisciplinary team, that mited to— Dysician. It is with responsibility for the are ponsibility for the are p			 4. The RN Nurse Manager (DON) or designee will au updated care plans 3 x wes 12 weeks and 5 x monthly months. Data will be reporthe QAPI team. 5. Corrective action will be complete by 04/14/17. 	idit ekly x x 6 rted to

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU! A. BUILC		CONSTRUCTION		DATE SURVEY COMPLETEO
		495384	B. WING	_	·		C 03/02/2017
	PROVIOER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		100	EET ADORESS. CITY. STATE, ZIP (FRANCIS MARION LANE, PO E RION, VA 24354	COOE	03/02/2011
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE	(X5) COMPLETION DATE
	team after each ass comprehensive and assessments. This REQUIREMENTS: This REQUIREMENTS: Based on staff intereview, the facility sthe current comprehensive care no longer an elopent of the clinical record of 2/28/17 and 3/1/17. The facility 5/8/15 but not limited to left tract infection, diabet vascular dementia, hearing. Resident #12's quart (MDS) assessment reference date (ARE resident with a cogn of 15 and without and delirium, psychosis, others. Resident #12 to nee people for bed mobile.	evised by the interdisciplinary sessment, including both the I quarterly review IT is not met as evidenced rview and clinical record taff failed to review and revise nensive care plan for 2 of 24 #12 and Resident #13). ed: failed to revise the current e plan when Resident #12 was nent risk. of Resident #12 was reviewed Resident #12 was admitted with diagnoses that included thumeral fracture, urinary stes mellitus, hypertension, pacemaker, and hard of terly minimum data set with an assessment of of 12/23/16 assessed the itive summary score of 6 out y signs or symptoms of or behaviors directed toward 2 was also assessed to have ior. Section G assessed d extensive assistance of 2 lity and toilet use and	F 2	280			
	transfers, locomotion hygiene and bathing	ance of two people for n off unit, dressing, personal . Resident #12 was pairment in upper extremity					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 4K721t

Facility IO: VA0086

If continuation sheet Page 23 of 67

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO. 09	<u> 338-0391</u>
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE S COMPLE	
		495384	B. WING			03/02	/2017
•	PROVIDER OR SUPPLIER	EALTH & REHABILITATION		100	REET ADDRESS, CITY, STATE, ZIP CODE FRANCIS MARION LANE, PO BOX 880 RION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE C	IX5I OMPLETION DATE
F 280	extremities. The current compret 1/10/17 identified Relopement risk r/t (relopement risk r/t (relopement risk r/t) (relopement Q (every) The February 2017 that read "Assess a function of wander guard is located on Written beside the control of the surveyor review Wandering Risk Assembly Question 6 read "Hewandering without panswer "No." 14. On longer gets up in up out of the bed should be the control of the surveyor observations, leating her meals. The surveyor interval/1/17 at 2:55 p.m. the current care plaafter the elopement	chensive care plan dated esident #12 to be an related to) dementia, impaired Interventions/tasks listed ALERT: Check function and an order and check placement and guard every shift (wander residents w/c (wheelchair)." order was "D/C (discontinue) wed the "Elopement/Unsafe sessment" completed 1/17/17. as the resident been observed ourposeful reason?" The Comments read "Resident #12 in her wheelchair. If she gets he prefers the recliner." wed Resident #12 on 2/28/17 in 3/1/17 at 8:10 a.m. During Resident #12 was in bed, The surveyor did not observe guard on any medical		280			

FORM CMS-2567(02-99) Previous Versions Obsolete

care plan.

elopement should have been resolved on the

Event ID: 4K7211

Facility ID: VAD086

If continuation sheet Page 24 of 67

PRINTED: 03/22/2017

	AND HUMAN SERVICES			,), 0938-0391
CENTERS FOR MEDICARE		T				TE SURVEY
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOI		ONSTRUCTION		MPLETEO
	495384	B. WING			03	C 3/02/2017
NAME OF PROVIOER OR SUPPLIER			_	EET AOORESS, CITY, STATE, ZIP COOE		
FRANCIS MARION MANOR HEALTH & REHABILITATION				FRANCIS MARION LANE, PO BOX 880 RION, VA 24354	<i>,</i>	
POCELY (FACH OFFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	IX5I COMPLETION OATE
F 280 Continued From pa	ge 24	F 2	80			
the above concern Resident #12's care was discontinued a an elopement risk of meeting on 3/1/17 at the conference on 2. The facility is the comprehensive the comprehensive Resident #13 was resident #13 was resident #13 was resident #16 was resident #18 was resident was extremity, depressing pulmonary disease the quarterly MDS (ARD (Assessment as having a BIMS (Status, an assessment as having a BIMS (Status, an assessment as requiring member for eating being totally dependent member for dressing the surveyor performance of Resident #13's in review, the surveyor that a wound cultur resident's vascular	ion was provided prior to the 3/2/17. Staff failed to review and revise care plan for Resident #13. The eadmitted to the facility on the wing diagnoses of, but not the interest in the pressure, and the most interest in the provided pressure on and chronic obstructive. The resident was coded on (Minimum Data Set) with an Reference Date) of 12/28/16 Brief Interview for Mental thent protocol) score of 15 out of 15. Resident #13 is also extensive assistance of 1 staff and personal hygiene and dent on 2 or more staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

month of February, 2017, the physician ordered "Doxycycline 100 mg (milligram) BID (twice a

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 25 of 67

RECEIVED MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			ON.	<u>/IB NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE	TIPLE CONSTRUCTION DING	1	(X3) DATE SURVEY COMPLETED
	495384	B, WING			C 03/02/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
FRANCIS MARION MANOR H	EALTH & REHABILITATION		100 FRANCIS MARION LANE, MARION, VA 24354	PO BOX 880	
PREFIX (EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD I O THE APPROPR	BE COMPLETION
2/10/17 at 2100 (9 On 2/13/17 the work the facility and show the facility and show "Methicillin Resistar (MRSA)" According to the number of the resident and husbar of this room change. The comprehensive the surveyor on 2/2 documentation was integrity r/t (related There was no documentation. The director of nurse surveyor on 3/1/17 surveyor notified the above documented who's responsibility care plan when the condition of the resistated "It is the resistates the order. The the care plan but we was no documented to the test of the resistant of the resistan	age 25 ays". This was started on pm) according to the MAR. and culture result returned to wed that it was growing nt Staphylococcus Aureus arses' notes on 2/13/17, it was desident #13 was notified of the nd the need to be moved to a nat she would not have a infection had cleared. The and verbalized understanding the per the nurses' notes. The care plan was reviewed by the care plan was reviewed by the noted: "Impaired skin to) Venous stasis BLE". Immentation that included the nd culture that grew MRSA or as moved to another room for asing was interviewed by the at approximately 10 am. The the director of nursing of the findings. The surveyor asked to was it to update the resident the was a change in the care or ident. The director of nursing tonsibility of the nurse that the nurses are able to update the have only had this computer the August and we are still		280		

FORM CMS-2567(02-99) Previous Versions Obsolete

The administrative team was notified of the above documented findings by the surveyor on 3/1/17 at

Event ID:4K7211

Facility ID: VA0086

If continuation sheel Page 26 of 67

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495384	B. WING		C 03/02/2017
	PROVIDER OR SUPPLIER S MARION MANOR HE	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 100 FRANCIS MARION LANE, PO B MARION, VA 24354	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ISHOULD BE COMPLETION
F 280	The surveyor asked comprehensive care On 3/2/17 at 8:20 a of Resident #13's cantries were noted date of 3/1/17: "2/13/17 culture (right) le (lower extresident placed in is	is pm in the conference room. If for a copy of the current the plan for Resident #13. It is, the surveyor found a copy that plan. The following by the surveyor with a revision the of venous stasis ulcer to (R) remity) positive for MRSA solation- contact I"	F 2	F309 Following physicia appropriately is a pteam at FMM	
SS=E	No further information was provided to the surveyor prior to the exit conference on 3/2/17. F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES SS=E FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		F3	and 11 physicians and all scenarios we Clarification orders received if needed. 2. All residents has potential to be affersame practice.	were called vere explained. s were ve the cted by the
	applies to all treatment facility residents. Bat assessment of a residents received accordance with propractice, the compressions.	fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered esidents' choices, including		3. Re-educated tear proper medication. will be reinforced of Skills Fair on April Nurse Managers haverifying start and MARs.	Education luring the 12. Assistant ave started

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES			<u>OI</u>	MB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
•					С
	495384	B, WING			03/02/2017
NAME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	
	TALTU O DELLA DILITATIONI		100 F	RANCIS MARION LANE, PO BOX 880	
FRANCIS MARION MANOR HE	ALIH & REHABILITATION		MARI	ON, VA 24354	
POETY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 309 Continued From pag		F	309	Continued	
The facility must energy provided to resident consistent with profethe comprehensive and the residents' g (I) Dialysis. The fact residents who requiservices, consistent of practice, the comprehences. This REQUIREMENT by: Based on staff interview, the facility storders for 5 of 24 R (Resident #4, #13, #1). The findings includes 1. The facility storders for Resident Resident #4 was ad 3/14/16 with the folial limited to anemia, and sease, high blood dementia, and hepathenergy must be storder for Mental protocol) of 00 out of the consideration of the	sure that pain management is a who require such services, essional standards of practice, person-centered care plan, loals and preferences. Sility must ensure that re dialysis receive such a with professional standards prehensive person-centered esidents' goals and AT is not met as evidenced traited and clinical record traited to follow physician's esidents in the survey sample #3, #8 and #11).			4. The RN Nurse Manager (DON) or designee will aud PRN meds and antibiotic mensure meds are given as or 5 x weekly x 12 weeks and monthly x 6 months. Data be reported to the QAPI teats. Corrective action will be complete by 04/14/17.	neds to rdered 5 x will um.

Facility ID: VA0086

dependent on 2 staff members for dressing,

personal hygiene and bathing.

PRINTED: 03/22/2017 FORM APPROVED

DE: / (()		O MEDICAID SERVICES				OM	B NO. 0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE C	ONSTRUCTION		X3) OATE SURVEY
STATEMENT AND PLAN C	OF OEFICIENCIES OF CORRECTION	10ENTIFICATION NUMBER:	1 ' '			ľ	COMPLETEO
							С
		495384	B. WING				03/02/2017
NAME OF	PROVIOER OR SUPPLIER			1	ET AOORESS, CITY, STATE, ZIP C		
EDANCE	S MARION MANOR H	EALTH & REHABILITATION		l	FRANCIS MARION LANE, PO B	IUX 880	1
FRANCI				MAI	RION, VA 24354	PDECTION	/VE\
(X4) 10 PREFIX TAG	/EACH DEFICIENCS	TEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	10 PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO B APPROPRI	E COMPLETION
F 309	During the clinical reported by the survey physician had order #4: Hydrocodone (milligram)-325 mg mouth twice daily for fadministration Received 1/16/17 at 2100 (9) the "medication was also review of the month of Jamentioned medical "Controlled Substa	record review on 3/1/17, it was yor that on 12/6/16 the red the following for Resident Acetaminophen 5 mg tablet Take 1 tab (tablet)by or pain. The MAR (Medication cord) for the month of January, ewed by the surveyor. On pm) it was documented that is not available". wed the narcotic sign out sheet inuary, 2017 for the above tion. According to the nece Administration Record" the treceived from the pharmacy		309			
	"STAT Box" that we room. On this list, 5 mg-325 mg was the resident until the delivered by the phonon of the adminition of the adminition of the survestant of the survestant of the survestant of the survestant of the physician unavailable medical stant as survestant of the physician of the phys	ximately 5:15 pm, the surveyor strative team of the above					

FORM CMS-2567(02-99) Previous Versions Obsolete

be obtained. The pharmacy will call the facility with the code and 2 nurses have to witness the

Event ID: 4K7211

Facility IO: VA0086

If continuation sheet Page 29 of 67

RECEIVED MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				01	VIB NO.	0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING					E SURVEY IPLETEO
	,	495384	B. WING			_		C 02/201 7
,	PROVIOER OR SUPPLIER	EALTH & REHABILITATION		100 FRANC	OORESS, CITY, STA CIS MARION LAN VA 24354			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	((E	PROVIOER'S PLAN EACH CORRECTIVE OSS-REFERENCEO		BE	(X5) COMPLETION DATE
F 309	No further informati surveyor prior to the 2. The facility st non-pharmacologic administration of pa #13. Resident #13 was re 4/7/15 with the follor limited to heart failu neurogenic bladder, disorder, vascular sextremity, depressic pulmonary disease. the quarterly MDS (ARD (Assessment fas having a BIMS (EStatus, an assessm of a possible score coded as requiring emember for eating a being totally dependent #13's management of Resident #13's management for dressin the surveyor performance of Resident #13: "Matablet by mouth on a complaints of leg pa at 2215 (10:15 pm), complaints of back pam) for complaints of back pam) for complaints of management for complaints of back pam) for complaints of management for complaints of back pam)	ion was provided to the e exit conference on 3/2/17. taff failed to document tal interventions prior to the ain medications to Resident readmitted to the facility on owing diagnoses of, but not ure, high blood pressure, multiple sclerosis, seizure stasis ulcer to right lower on and chronic obstructive. The resident was coded on (Minimum Data Set) with an Reference Date) of 12/28/16 Brief Interview for Mental nent protocol) score of 15 out of 15. Resident #13 is also extensive assistance of 1 staff and personal hygiene and dent on 2 or more staffing and bathing. Interview of the diagram of the dia	F 3	D9				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 30 of 67

MAR 3 0 2017 MOH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OFFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI	TIPLE CONSTRUCTION	(X3) DATE SURVEY	
-	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPLETED
					С
		495384	B. WING		03/02/2017
	PROVIDER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		STREET AODRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF OEFICIENCIES MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
F 309	Continued From pa	ge 30	F3	809	,
	for the above docur pain medications w There were no non-documented prior to pain medications. Resident #13's comalso reviewed by the of Pain the following documented: "Anticipate her respond immediate "Monitor/record (signs or symptoms "Monitor/record of resident) compla pain treatment " (namassistance when in ask for pain medica pain is experienced alleviates pain" The administrative of documented finding approximately 5:15 No further informatisurveyor prior to the 3. The facility staff physician ordered in by mouth BID x 7 documented on 3/1/17 and 1/1/17 and 1/1/17 and 1/1/17 and 1/1/17 and 1/1/17 and 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	team was notified of the above by the surveyor on 3/1/17 at pm. on was provided to the exit conference on 3/2/17. If alled to administer the nedication doxycycline 100mg			

PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,		<u>O</u>	MB NO. 0938-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ' '		INSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495384	B. WING			. C 03/02/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	T AOORESS, CITY, STATE, ZIP COOE	
				100 FI	RANCIS MARION LANE, PO BOX 880	
FRANCIS		EALTH & REHABILITATION		MAR	ON, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLETION
F 309	Continued From pa	iae 31	F 30	09		
	pressure, decubitus ulcer, hypothyroidism, and adult failure to thrive.					
	assessment with an (ARD) of 2/6/17 assessment with an assessment with a second with	ent minimum data set (MDS) n assessment reference date sessed the resident with a score of 99. Section G coded lire assistance with activities of				
	Review of the clinical record revealed the physician had ordered the medication doxycycline 100mg by mouth BID x 7 days on 2/18/17.					
	administration records 13 doses of the med	reviewed the medication rded (MAR) that revealed only dication had been e 14 ordered doses.				
	all the doses had be	to look at the MAR and see if een given. After looking she by didn't give them all."				
	asked to look at the	he director of nurses was number of doxycycline MAR. She said "looks like 13				
	other administrative	ned the administrator and e staff of the medication issue e day meeting on 3/1/17 at				
	exit conference on 3 4. For Resident #8,	on was provided prior to the 3/2/17. the facility staff failed to follow n regards to no bowel				

FORM CMS-2567(02-99) Previous Versions Obsolete

movements for 72 hours.

Event IO:4K7211

Facility IO: VA0086

If continuation sheet Page 32 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,		OMB NO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495384	B. WING		C 03/02/2017
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET AOORESS, CITY, STATE, ZIP COOE	
			i	100 FRANCIS MARION LANE, PO BOX 8	80
FRANCIS	MARION MANOR HI	EALTH & REHABILITATION		MARION, VA 24354	
I X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPROPRIED OFFICIENCY)	ULO BE COMPLETION
F 309	Continued From pa	ne 32	F 3	:na	
1 303	•	Imitted to the facility on	1 3	109	
	05/27/16 and readn	nitted to the facility on nitted on10/02/16. Diagnoses ited to anemia, anxiety,			
		ia, urinary tract infection and			
The most recent MDS with an ARD (assessment reference date) of 02/10/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. Resident #8's clinical record was reviewed on		OS with an ARD (assessment			
		ed bowel movement records ecember, January and			
	February. For the m	onth of December, the			
	Resident went for a (12/01-12/06/16) with	period of 5 days th no recorded bowel			
	movement and a pe	eriod of 3 days			
		th no recorded bowel month of January, the		•	
	Resident went for a				
	movement and a pe	th no recorded bowel riod of 3 days			
		th no recorded bowel month of February, the			
	Resident went for a	period of 3 days			
	(02/03-02/05/17), a (02/06-02/10-17), a				
	(02/06-02/10-17), a (02/11-02/19/17), a				
	(02/21-02/25/17 and				
	(02/15-02/28-17) with movements.	th no recorded bowel			
	signed POSs (physic	al record also contained cian's order summaries) for			
		mber, January and February. d an entry which read in part			
	"Bisac-evac 10mg s	upp. (suppository) for			İ
	Duicolax-unwrap an	d insert 1 suppository rectally			1

FORM CMS-2567(02-99) Previous Versions Obsolete

every 72 hours as needed for constipation".

Event 10: 4K7211

Facility IO: VA0086

If continuation sheet Page 33 of 67

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					O	MB NO. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT(PLE CONSTRUCT(ON A. BU(LO(NG			(X3) OATE SURVEY COMPLETEO
		495384	B. WING _		····	C 03/02/2017
	PROVIOER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		STREET AOORESS, CITY, 100 FRANCIS MARION MARION, VA 24354		
(X4) (O PREF(X TAG	(EACH OEF(C(ENC)	TEMENT OF OEF(C(ENC(ES ' MUST BE PRECEOEO BY FULL SC (OENT(FY(NG (NFORMAT(ON)	(O PREF(X TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCEO TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 309	Continued From pa	ge 33	F 30	09		
	records) for the mo and February were MAR contained an "Bisac-evac 10mg sinsert 1 suppository needed for constipations signed as having be	Rs (medication administration on the of December, January reviewed on 03/01/17. Each entry which read in part supp for Dulcolax-unwrap and rectally every 72 hours as ation". This order had not been een administered at any time in February, and only 1 time in				,
. *	orders was discuss	following the physician's ed during a meeting with the on 03/01/17 at approximately				
	5. The facility staff	ion was provided prior to exit. failed to monitor and evaluate ponse to treatment for				
	2/28/17 and 3/1/17 initially 12/2/16 and 2/27/17 with diagnoral limited to pneumon pulmonary disease hypothyroidism, act fracture, chronic luruse, osteoporosis,	of Resident #11 was reviewed. Resident #11 was admitted readmitted 2/13/17 and oses that included but not ia, sepsis, chronic obstructive, anxiety, chronic pain, ute lumbar compressioning disease, chronic steroid gastroesophageal reflux emia, seizures, right eye facial paralysis.		· · ·		
	(MDS) assessment reference date (AR resident with a cogn	nission minimum data set with an assessment D) of 12/9/16 assessed the nitive summary score of 15 out Cognitive Summary. Section				

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
			ļ			С
		495384	B. WING			03/02/2017
NAME OF	PROVIOER OR SUPPLIER			STR	REET AOORESS, CITY, STATE, ZIP COOE	
FDANCE	C MADION MANOD III	TALTU S DEHADU ITATION		100	FRANCIS MARION LANE, PO BOX 880	
FRANCI	S MARIUN MANUR H	EALTH & REHABILITATION		MA	ARION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIOER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	O BE COMPLETION
F 309	O9 Continued From page 34 G assessed the resident to need limited assistance of 1 person for transfers. Resident			109		
	#11 required extensive assistance of one person for toileting. Resident #11 was assessed to be occasionally incontinent of bowel in Section H Bladder and Bowel.					
	initiated 12/16/16 id focus r/t (related to) side effects of medi listed included to en prunes each day, m effects of constipation of any problems. M (whenever needed)	ent comprehensive care plan entified constipation as a decreased mobility, pain, cations. Intervention/tasks courage warm prune juice or onitor medications for side on. Keep physician informed onitor/document /report prn s/sx (signs/symptoms) of d to constipation. Record attern each day.				
	The surveyor reviewed the B&B-Bowel and Bladder Elimination Report for February 2017. The B&B report revealed Resident #11 did not have a bowel movement for 5 days from 2/1/17 through 2/5/17, 2/13/17 through 2/17/17 (5 days) and 2/20/17 through 2/23/17 (4 days).		•			
	#11 had orders for E mg (milligrams) cap mouth twice a day a Documentation on the indicated Resident #7p-7a shift on 2/3/17 reverse side of the mecord did not reveal.	2/8/17 medication d was reviewed. Resident locusate sodium softgel 100 sule for > Colace 1 cap by s needed for constipation. he February 2017 MAR 11 received Colace on the f, 2/4/17, and 2/5/17. The hedication administration documentation of the fication administered was				

effective.

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		NSTRUCTION	(X3	3) DATE SURVEY COMPLETED		
			1		_		С		
		495384	B. WING				03/02/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET	T ADDRESS, CITY, STATE	. ZIP CODE			
A MICI	O STADIONI MANIOD U	THE PERMITTATION			RANCIS MARION LANE,	PO BOX B80			
FRANCI	S MAKION MANOR III	EALTH & REHABILITATION		MARIO	ON, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIAT			
	Continued From pa The 2/1/17 through administration reco #11 had orders for I (milligrams)/15 ml (Constulose then 20 needed q (every) 8 documentation Res The 2/1/17 through administration reco constipation and re- mg/15 ml oral susp of Magnesia (MOM needed constipation documentation that The surveyor review administration reco 2/23/17. Resident #11 had o (Grams)/15 ml (mill Constulose then 20 daily as needed for Resident #11 receiv 2/18/17, 2/19/17 an was no indication if was effective. Ther documented from 2 days) and 2/20/17 ti	age 35 n 2/8/17 medication ord was reviewed. Resident Lactulose 100 mg (milliliters)solution for > 0 ml (15 mg) by mouth as 15 hours. There was no 16 sident #11 received Lactulose. 16 n 2/8/17 medication 17 ord also had a second order for 18 n 2/8/18 medication 19 of (suspension) for >Phillips Milk 19 30 ml by mouth every day as 19 n." There was no 10 t Resident #11 received MOM. 10 wed the medication 11 orders for Lactulose 10G 12 liliters) solution for > 10 ml (20 G) by mouth twice	F3		DEFICIE	NCY)			
	The surveyor review progress notes. Th	wed the February 2017 nere was no documentation in of Resident #11's bowel					į		

FORM CMS-2567(02-99) Previous Versions Obsolete

status.

Event ID: 4K7211

Facility ID: VA0086

If continuation shee! Page 36 of 67



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OE FICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
					С
		495384	B. WING		03/02/2017
,,,,,,	PROVIOER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		STREET AOORESS, CITY, STATE, ZIP COOE 100 FRANCIS MARION LANE, PO BOX 88 MARION, VA 24354	ю
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		JLO BE COMPLETION
F 309	does print out a represidents that have	ge 36 ., the DON stated the facility ort each day for those not had a bowel movement. e reports are given to the	F3	309	
F 314 SS≅D	The surveyor informed the administrative staff of the concern with Resident #11's bowel movement status during the end of the survey meeting on 3/2/17 at 12:20 p.m. No further information was provided prior to the exit conference on 3/2/17. 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES		F 3	F314 Following infection conguidelines during wound priority for the team at 1	d care is a
,	(b) Skin Integrity - (1) Pressure ulcers. comprehensive ass facility must ensure (i) A resident receive professional standa pressure ulcers and ulcers unless the incidemonstrates that the compressional standary treatment professional standary the professional standary healing, prevent inferfrom developing. This REQUIREMENT by: Based on observation document review, as	Based on the essment of a resident, the		 The RN providing was counseled regardin dressing techniques. Reappears to have sustaine effects from the identification practice. All residents receiving care have the potential affected by the same provided. The peer observation completed action plan initiated education will be provided that the provided in the skills fair. 	g proper esident #3 ed no ill ed ng wound to be actice. Peer to leted and l. Re-

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO	<u>. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '		PLE CONSTRUCTION G	(X3) DATE SURVEY CDMPLETED		
		495384	B. WING	;		1	C 02/2017	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
FRANC	MARION MANOR H	EALTH & REHABILITATION		i .	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(XS) COMPLETION DATE	
F 314	Continued From pa	ge 37	F3	31∠	4			
	·	ound care for 1 of 26			Continued			
	The findings include	ed:						
	The facility staff fail- wound care for Res	ed to wash hands during ident #3.			4. The RN Nurse Manage (DON) or designee will o wound care to audit property.	bserve		
	record on 3/1/17 an admitted to the facil that included but no	wed Resident #3's clinical d 3/2/17. Resident #3 was ity 10/5/16, with diagnoses t limited to anemia, high blood ulcer, hypothyroidism, and e.			hygiene to be completed a weekly x 12 weeks and m for six months. Data will reported to the QAPI team	onthly be		
	assessment with an (ARD) of 2/6/17 ass cognitive summary:	nt minimum data set (MDS) assessment reference date essed the resident with a score of 99. Section G coded re assistance with activities of			5. Corrective action will complete by 04/14/17.	be		
	dated 1/13/17 identi	nt comprehensive care plan fied the resident had a pairment and pressure.						
	2:15 p.m., with the v care nurse cleaned table; then gathered at the treatment cart Resident #3's room. hands and put on gloves and placed o cleanser and gauze, Resident #6's hip. Scleanser on another	ved wound care on 3/1/17 at vound care nurse. The wound and draped the over bed of the supplies for wound care and carried them into Using hand gel cleaned her oves then removed the old in the hip. She removed her in new gloves, using wound cleaned the wound on the then sprayed wound gauze and cleaned the #6 coccyx area. She then						

FORM CMS-2567(02-99) Previous Versions Obsolete

Evenj (D: 4K7211

Facility ID: VA0086

If continuation sheet Page 38 of 67

CULIVED

mas 30 2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		405004				С
		495384	B. WING			03/02/2017
	PROVIDER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		STREET ADDRESS, CITY 100 FRANCIS MARION MARION, VA 24354	I LANE, PO BOX 880	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD NCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 314	coccyx area wound dressing on the hip placing the allevyn removed her gloves assist the CNA in powound care nurse wound care	essing and placed it on the ; then place an allevyn and wrote the date on it after on the resident's hip. She is and put on clean gloves to ositioning the resident. The washed her hands at the rund care and after she are determined the administrator and estaff of the wound care issue to day meeting on 3/1/17 at eyor requested the facility sing/wound care.	F	14		
F 328 SS≃D	hygiene and don glodressing, if present, biohazard disposal perform hand hygie Apply wound dressi the organization's profapplication and ir remove PPE (perso and perform hand hand hand hand hand hand hand hand	on was provided prior to the 3/2/17. (h)(i)(j) TREATMENT/CARE EDS ensure that residents receive d care to maintain mobility	F3	₂₈ equipme clean an		in a er for all

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 39 of 67

RECEIVED

MAR 3 0 2017

ADH/OFC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O!	<u>MB NC</u>	D. <u>0938-0391</u>
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495384	B. WING			03	C 3/02/2017
NAME OF F	PROVIOER OR SUPPLIER		<u> </u>	ST	REET AOORESS, CITY, STATE, ZIP COOE	<u> </u>	······································
				100	0 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	5 MARION MANOR HI	EALTH & REHABILITATION		M/	ARION, VA 24354		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO. PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPF OEFICIENCY)) BE	(X5) COMPLETION DATE
F 328	Continued From pa	ige 39	_ F3	328			
	(i) Provide foot care with professional sta to prevent complica	e and treatment, in accordance randards of practice, including ations from the resident's			Continued		
	medical condition(s	•			1. Concentrators for residents		
	(ii) If necessary, ass appointments with a arranging for transp			and #7 were cleaned and filter changed immediately.	rs		
	appointments				2. All residents who utilize		
		erostomy, or ileostomy care. sure that residents who			concentrators have the potenti	ial	
		ureterostomy, or ileostomy			to be affected by the same		
	professional standa	uch care consistent with ords of practice, the son-centered care plan, and			practice. So, all concentrators were cleaned and filters chang		
	the resident's goals				3. Process of changing filters	was	
		no is fed by enteral means priate treatment and services			changed to every two weeks.		
	to prevent compl	lications of enteral feeding			4. The RN Nurse Manager		
		nited to aspiration pneumonia, dehydration, metabolic			(DON) or designee will obser	ve	
		nasal-pharyngeal ulcers.			cleanliness of the concentrator	rs	
	(h) Parenteral Fluids	s. Parenteral fluids must be			by audit 4 x weekly x 12 week		
	administered consis	stent with professional			and 4 x monthly thereafter. Da	ata	
		e and in accordance with			will be reported to the QAPI		
	physician orders, the person-centered car	re plan, and the resident's			team.		
	goals and preference				5 Compating action will be		
	and tracheal suction that a resident who i including tracheosto	including tracheostomy care ning. The facility must ensure needs respiratory care, omy care and tracheal ed such care, consistent with			5. Corrective action will be complete by 04/14/17.		

professional standards of practice, the

PRINTED: 03/22/2017 FORM APPROVED

	TAICHT OF THEVETT			(MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
AND PLAN O	P CORRECTION		A. BUILDING	<i></i>	c ·
		495384	B. WING_		03/02/2017
	PROVIDER OR SUPPLIER	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX B80	
FRANCIS	MARIOI MARIOR III	EALIT GENERALIZATION		MARION, VA 24354	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TD THE APPROF DEFICIENCY)	D BE COMPLETION
	residents' goals and this subpart. (j) Prostheses. The resident who has a and assistance, constandards of practic person-centered cand preferences, to prosthetic device. This REQUIREMED by: Based on observation document review a facility staff failed to equipment was mas anitary manner for #5 and Resident #7. The findings included 1. The facility staff the oxygen concent #5. The surveyor review Resident #5 on 2/26 was admitted to the	e facility must ensure that a prosthesis is provided care nsistent with professional ce, the comprehensive are plan, the residents' goals o wear and be able to use the NT is not met as evidenced tion, staff interview, facility nd clinical record review, the consure respiratory care intained in a clean and r 2 of 24 residents (Resident 7).	F 32		
	pain, heart failure, hypertension, urina fibrillation, hyponat disorder, anxiety, c branch block. Resident #5's quar	hypoxemia, pulmonary ry tract infections, atrial remia, major depressive ataracts, and right bundle terly minimum data set (MDS) n assessment reference date			

FORM CMS-2567(02-99) Previous Versions Obsolete

(ARD) of 1/7/17 assessed the resident with a

Event ID: 4K7211

Facility ID: VA0086

If continuation sheel Page 41 of 67

KECEIVED VOH/OFC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495384	B. WING _		C 03/02/2017
	PROVIDER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 328	without signs or synor behaviors. Resider tequire oxygen while Resident #5's curre initiated 10/15/16 and CHF (congestive he and treated with O2 cannula), diuretics a interventions/tasks medications as ordedistress and report (whenever necessatolerated by resident The February 2017 reviewed. The curro oxygen was 2 liters tolerated by resident The surveyor observations as of the head of the bed oxygen concentrato of the bed. The surveyor of the bed. The surveyor amount of oxygen February 2017 amount of oxygen February 2017 reviewed. The curro of the bed. The surveyor observation of the bed oxygen concentrato of the bed oxygen concentrato of the bed oxygen February 2017 reviewed. The surveyor observation of the bed oxygen concentrator and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with a grayistated the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible concentrators and with the provided the filter was who was responsible to the provided the provided the filter was who was responsible to the provided the provided the pro	score of 12 out of 15 and nptoms of delirium, psychosis dent #5 was assessed to e a resident at the facility. Int comprehensive care plan and revised 1/9/17 identified eart failure) as a focus area of (oxygen) via NC (nasal and fluid restriction. We also disted in part were administer ered, monitor for respiratory to MD (medical doctor) promanding to MD (medical doctor) proman	F 3:	28	

FORM CMS-2567(02-99) Previous Versions Obsolete

The surveyor interviewed the restorative C.N.A.

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 42 of 67

MAR 30 2017 MOH/OLC

PRINTED: 03/22/2017 FORM APPROVED

		AND HOWAN SERVICES					1 0020 0204	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			Т). 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495384	B. WING			03	C /02/2017	
NAME OF I	PROVIDER DR SUPPLIER		[S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRANCIS	MARION MANOR H	EALTH & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN DF CORRECTIO (EACH CORRECTIVE ACTION SHDULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 328	stated he and a repcompany rounded and performed mai concentrators. Rest the surveyor with the was dated 2/8/17. stated filters were was filter needed to be the dishwasher. The there were extra ox. The surveyor informate above concerns in the end of the dap.m. and requested maintenance of oxy. The facility policy tit Therapy-Francis Maile 3/2/17. The policy of Concentrators: 1. Sadhered by placing environment that is walls, drapes, curtamaterials, and at less heat sources. a. Not delivery system in a 2. Wipe exterior with as needed. 3. Foliofor maintenance and recommendations."	Da.m. Restorative C.N.A. #4 presentative from the oxygen monthly and checked the filters intenance on the storative C.N.A. #4 provided he last inspection and the form The restorative C.N.A. #4 vashed at least monthly and if he cleaned they were washed in he restorative C.N.A. #4 stated hygen filters kept at the facility. The facility policy on he facility policy on he restorative on 3/1/17 at 5:10 If the facility policy on he facility policy on he facility policy on he facility policy on he facility same to be he system in a clutter-free he well ventilated, away from he closet. It approved cleaning solution he manufacturer's instructions he dother safety	F3	328				
	exit conference on	on was provided prior to the 3/2/17.						

#7.

2. The facility staff failed to ensure the filter on the oxygen concentrator was clean for Resident

TH AND HUMAN SERVICES

PRINTED: 03/22/2017 FORM APPROVED

		AND HUMAN SERVICES			_		0.0938-0391
		& MEDICAID SERVICES	T				TE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	CO	MPLETED C
		495384	B. WING				/02/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	S MARION MANOR H	EALTH & REHABILITATION			FRANCIS MARION LANE, PO BOX 880 RION, VA 24354		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 328	Continued From pa	age 43	F3	328			
	and readmitted 2/2 included but not lim gastritis, esophagit hernia, hypertensio pulmonary disease failure, chronic kidr hypothyroidism, se dementia with delu diabetes mellitus, a coronary artery dise hyperlipidemia, dia stroke.	dmitted to the facility 9/10/14 2/17 with diagnoses that nited to ischemic colitis, is, duodenal ulcer, hiatal on, chronic obstructive , chronic hypoxic respiratory ney disease stage 4, vere dysmobility, vascular sions, major depression, atrial fibrillation, schizophrenia, ease, sleep apnea, betic foot ulcer, and history of					
	assessment with a (ARD) of 9/11/16 coognitive summary Section C Cognitive Treatments, Proceethat Resident #7 regident. The mos	all minimum data set (MDS) in assessment reference date oded the resident with a score of 00 out of 15 in the Patterns. Section O Special dures, and Programs coded beceived oxygen while a trecent quarterly MDS with an accorded the resident with the era resident.					
	contained a focus a initiated 9/12/16 an Interventions/tasks signs/symptoms of to MD (medical donecessary); respira increased heart ratheadaches, lethard	ent comprehensive care plan area for oxygen therapy id revised 12/12/16. were in part: Monitor for respiratory distress and report ctor) prn (whenever ations, pulse oximetry, te, restlessness, diaphoresis, ty, confusion, atelectasis, ty, pleuritic pain, accessory					

FORM CMS-2567(02-99) Previous Versions Obsole(a

muscle usage, skin color. Promote lung expansion and improve air exchange by positioning with proper body alignment. Elevate

Even(ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 44 of 67

RECEIVED MAR 3 0 2017 VOH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES							(0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION			(X3) DAT	TE SURVEY MPLETED
		495384	B. WING _					1	C / 02/201 7
l	PROVIDER OR SUPPLIER MARION MANOR HE	EALTH & REHABILITATION		100 FR	TADDRESS, KANCIS MAR ON, VA 24:	ION LANE,	, ZIP CODE PO BOX 880		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CO	RRECTIVE A	OF CORRECTION SHOUL O THE APPROINCY)	D BE	(X5) COMPLETION DATE
	read "O2 (oxygen) (via nasal cannula as The surveyor obser 12:20 p.m. as the offeeding her. Reside oxygen concentrato and the oxygen conliters/per minute. Rhave the nasal cannular the surveyor obser 3/1/17 at 8:00 a.m. positioned at 2 liters had the nasal cannular the surveyor locate registered nurse to on the back of the oa.m., QA RN remove concentrator. The fiwhitish to grayish sugot a filter problem." was responsible for RN stated "Restorat #4 (RCNA #4)." The surveyor interview on 3/1/17 at 8:40 stated he and a representations. Rest the surveyor with the surve	dent's tolerance. th 2017 physician order sheet (a) (at) 2 L/M (liters per minute) is tolerated." ved Resident #7 on 2/28/17 at certified nursing assistant was cent #7 was observed with an ir to the left side of her bed centrator was set at 2 cesident #7 was observed to hula in her nostrils. ved Resident #7 again on The oxygen concentrator was filter minute and Resident #7 hala positioned in her nostrils. d the quality assurance check the oxygen filter located xygen concentrator. At 8:05 ced the filter from the oxygen filter was covered with a hibstance. QA RN stated "We if The surveyor asked who cleaning the filters and QA ive certified nursing assistant ewed the restorative C.N.A. a.m. Restorative C.N.A. a.m. Restorative C.N.A. a.m. Restorative C.N.A. a.m. Restorative C.N.A.	F 32	28					

FORM CMS-2567(02-99) Previous Versions Obsolete

stated filters were washed at least monthly and if

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 45 of 67

RECEIVED
MAR 3 0 2017

ADH/OFC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ' '	LTIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
					С
		495384	B. WING		03/02/2017
	PROVIOER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		STREET AOORESS, CITY, STATE, ZIP COOE 100 FRANCIS MARION LANE, PO BOX 88 MARION, VA 24354	0
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		LO BE COMPLÉTION
F 328	the dishwasher. Th	ge 45 e cleaned they were washed in ne restorative C.N.A. #4 stated ygen filters kept at the facility.	F	328	
	the above concern in the end of the da	ned the administrative staff of with the care of oxygen filters y meeting on 3/1/17 at 5:10 the facility policy on gen equipment.			
	Therapy-Francis Ma 3/2/17. The policy of Concentrators: 1. Sadhered by placing environment that is walls, drapes, curta materials, and at leat sources. a. No delivery system in a 2. Wipe exterior with	Safety issues are to be the system in a clutter-free well ventilated, away from ins, bedding, combustible ast eight (8) feet away from OTE: Do not place oxygen a closet. th approved cleaning solution ow manufacturer's instructions d other safety		F332	
F 332 SS=D	exit conference on 3 483.45(f)(1) FREE 0 RATES OF 5% OR	OF MEDICATION ERROR	F3	Ensuring med error rate or below is a priority for at FMM 1. Education was provided.	the team le to
	(1) Medication error greater; This REQUIREMEN	rates are not 5 percent or IT is not met as evidenced ion, staff interview, facility		nurse caring for resident and #24 regarding med j inappropriate crushing of Cont	pass and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OM	<u>1B NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:] ` `		E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		495384	B. WING	·		03/0	0 2/2017
	PROVIDER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 332	facility slaff failed to rate was less than \$24 Residents in the #14 and #24). The findings include 1. The facility stadminister a medicate during the medicate during the medicate Resident #14 was r 11/15/16 with the folimited to high blood constipation, atrial fedema. The reside MDS (Minimum Dati (Assessment Referrequiring extensive for eating and person was also coded as I staff member for bate During the medicate made by the survey Licensed Practical Nesident Imdur 30 melease) I tablet. Leprior to the administresident and the mesauce. LPN #1 products.	and clinical record review, the orensure the medication error properties percent which affected 2 of a survey sample (Residents ed: taff failed to properly ation, Imdur, to Resident #14 on pass and pour observation. The admitted to the facility on allowing diagnoses of, but not dipressure, dementia, fibrillation, and generalized and was coded on the quarterly ta Set) with an ARD ence Date) of 1/20/17 as assistance of 1 staff member and hygiene. Resident #14 being totally dependent on 1	F3	332	2. All residents have the potential to be affected by the same practice. 3. Education provided and whose reinforced during the skilfair. Requested the pharmach bold the alert when the medicannot be crushed. 4. The RN Nurse Manager (DON) or designee will observed passes 4 x weekly x 12 weeks and 4 x monthly x 6 months. Data will be report the QAPI team. 5. Corrective action will be complete by 04/14/17.	will lls cy to l erve	
		ved the resident's MAR stration Record) for the month					

FORM CMS-2567(02-99) Previous Versions Obsolete

of March, 2017, under the medication Imdur, the following was noted: "Not to be chewed or

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 47 of 67

RECEIVED
MAR 3 0 2017
VOH/OLC

PRINTED: 03/22/2017 FORM APPROVED

		A MEDICAID CEDVICES			0	MB NO. 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T			(X3) OATE SURVEY
	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	COMPLETEO
		495384	B. WING			C 03/02/2017
NAME OF F	PROVIOER OR SUPPLIER	-	<u>' </u>	STR	EET AOORESS, CITY, STATE, ZIP COOE	
				100	FRANCIS MARION LANE, PO BOX 880	
FRANCIS	MARION MANOR HE	EALTH & REHABILITATION		MAI	RION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE COMPLETION
F 332	Continued From pa	ge 47	F3	32		
	copy of the do not of registered nurse #1 a copy of the policy That Should Not Be under the section "C Should Not Be Crus	, the surveyor requested a crush medication policy from . The surveyor was provided titled "Oral Dosage Forms Crushed". In this policy Dral Dosage Forms That shed" listed Imdur tablets as ons that are not to be crushed.				
	documented finding the medication, Imp	sing was notified of the above as concerning the crushing of dur, prior to the administration be director of nursing stated a cannot crush."				
	On 3/1/17 at approx administrative team documented finding	kimately 5:15 pm, the was notified of the above us.		-		
	No further informati surveyor prior to the	on was provided to the exit conference on 3/2/17.				
	administer a medica	aff failed to properly ation, Potassium Chloride, to give medication pass and				
	10/5/15 with the foll limited to high blood osteoporosis, deme resident was coded (Minimum Data Set Reference Date) of	admitted to the facility on owing diagnoses of, but not diagnoses of, but not disorder, entia, and depression. The on the annual MDS) with an ARD (Assessment 12/21/16 as having a BIMS Mental Status, an assessment				

FORM CMS-2567(02-99) Previous Versions Obsolete

protocol) score of 2 out of a possible score of 15. Resident #24 was also coded as requiring

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 48 of 67

RECEIVED MAR 3 0 2017 ADHIOFC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION 3	(X3) OATE SURVEY COMPLETEO
						С
		495384	B. WING			03/02/2017
NAME OF F	PROVIOER OR SUPPLIER				STREET AOORESS, CITY, STATE, ZIP COOE	
				-	100 FRANCIS MARION LANE, PO BOX 880	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION			MARION, VA 24354	
(X4) IO PREFIX TAG	(FACH OFFICIENCY	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	IX	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	O BE COMPLETION
F 332	dressing and perso	ce from 1 staff member for	F 3	332	2	
i.	made by the survey Licensed Practical I resident Potassium release) 20 meq 1 t medication prior to medication to the rewas placed in apple	yor on 3/1/17 at 8:30 am, Nurse (LPN #1) gave the Chloride ER (extended tablet. LPN #1 crushed this the administration of the esident and the medication e sauce. LPN #1 proceeded in and administrated the above				•
	(Medication Administration of March, 2017, und Chloride, the following t	wed the resident's MAR stration Record) for the month der the medication Potassium ing was noted: "Not to be . May be mix in water. Do not				:
	documented finding the medication Pota administration to the nursing stated "Tha	sing was notified of the above gs concerning the crushing of assium Chloride prior to the e resident. The director of at's one that you cannot crush in water then administer it to				
	On 3/1/17 at approx administrative team documented finding	ximately 5:15 pm, the n was notified of the above gs.				
F 333 SS≈D	No further informati surveyor prior to the 483.45(f)(2) RESID SIGNIFICANT MED	ion was provided to the e exit conference on 3/2/17. PENTS FREE OF D ERRORS	F3	333	3	

PRINTED: 03/22/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495384	B. WING	·	C 03/02/2017
	PROVIDER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP (100 FRANCIS MARION LANE, PO E MARION, VA 24354	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 333	Continued From pa	age 49	 F;	333	
	483.45(f) Medicatio	-		F333	
	The facility must en	sure that its-		Ensuring residents significant med en	
	medication errors.	e free of any significant		priority for the tea	
	by:	NT is not met as evidenced		1. Nurse re-educa	
	review, the facility s	erview and clinical record staff failed to ensure 2 of 24 t #7 and Resident #12) were medication error		proper administrat when using sliding	
	The findings include			2. All residents re scale insulin have	the potential to
	was administered th	failed to ensure Resident #7 he correct physician ordered		be affected by the	same practice.
	insulin.			3. Re-education re pass, including slice	
	and readmitted 2/22 included but not limit gastritis, esophagitis	Imitted to the facility 9/10/14 2/17 with diagnoses that ited to ischemic colitis, s, duodenal ulcer, hiatal		be reinforced during fair April 12, 2017	ng the skills
	pulmonary disease, failure, chronic kidno hypothyroidism, sev	n, chronic obstructive chronic hypoxic respiratory ey disease stage 4, vere dysmobility, vascular sions, major depression,		4. The RN Nurse I (DON) or designed med passes 4 x we	e will observe eekly x 12
	diabetes mellitus, at coronary artery dise	trial fibrillation, schizophrenia,		weeks and 4 x more months to ensure padministration/dos Data will be report	proper se of insulin.
	assessment with an	al minimum data set (MDS) assessment reference date		QAPI team.	
	` '	ded the resident with a score of 00 out of 15 in Patterns.		5. Corrective action complete by 04/14	

PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>0. 0938-0391</u>
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		CONSTRUCTION		ATE SURVEY OMPLETEO
		495384	B. WING			0:	C 3/ 02/2017
	PROVIOER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		100	EET AOORESS, CITY, STATE, ZIP C FRANCIS MARION LANE, PO BI RÍON, VA 24354		
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	Κ	PROVIOER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE	(X5 COMPLETION DATE
F 333	initiated 9/12/16 ide diabetic foot ulcer re	ge 50 nt comprehensive care plan ntified the resident had a elated to diabetes and read in part to monitor blood	F3	33			
·	physician orders ret "Novolog U100 per meals & (and) bedti Documentation She (body mass index) : circled for Resident read "70-150=0 unit	tet read "Overweight BMI 25-29.9." This category was #7. The corrective insulin :s; 151-200=2 units; i1-300=6 units; 301-350=8					;
	sugars and identified 2/1/17 0615 blood swas administered insulin was blank. Elements with the sugar should have received and the sugar should have received and the sugar sug	ved the results of the blood d the following concerns: ugar was 198 yet no insulin The column for correction Based on the order, Resident eived 2 units. There was no nt received the insulin.					
	157 yet no insulin w for correctional insu on the physician ord	sugar was documented as as administered. The column lin given was blank. Based ler, Resident #7 should have nere was no evidence d the insulin.					
	221. The amount of was blank. Residen	sident #7's blood sugar was f correctional insulin given at #7 should have been there was no evidence the					

FORM CMS-2567(02-99) Previous Versions Obsolete

resident received the insulin.

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 51 of 67

MAR 30 2017

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

OUNTERFOR THE STATE OF THE STAT			OMB NO	D. 0938-0391		
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION		ATE SURVEY OMPLETEO
		495384	B. WING		0:	C 3/ 02/201 7
	PROVIOER OR SUPPLIER S MARION MANOR HI	EALTH & REHABILITATION		STREET ACCRESS, CITY, STATE 100 FRANCIS MARION LANE, MARION, VA 24354	, ZIP COOE	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		ACTION SHOULO BE O THE APPROPRIATE	(X5] COMPLETION DATE
F 333	sugar was docume documentation that administered. Resident 2 units. The surveyor review with the director of 3:00 p.m. The DOR evidence Resident correct amount of indocumentation. The surveyor information above concernate meeting on 3/1/17 and 3/1/17 and 3/1/17 and 3/1/17 and 3/1/17 and 3/1/17 and 3/1/17 and 3/1/17 to the facility 5/8/15 but not limited to left tract infection, diabove concernate and and and and and and and and and and	47 p.m.), Resident #7's blood nted as 197. There was no correction insulin was ident #7 should have received wed the blood sugar results nursing (DON) on 3/1/17 at N acknowledged there was no #7 was administered the nsulin based on the ned the administrative staff of during the end of the day at 5:10 p.m.	F3	:33		

others. Section G assessed Resident #12 to

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES		& MEDICAID SERVICES			O	MB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495384	B. WING			C 03/02/2017
NAME OF F	PROVIOER OR SUPPLIER			STR	EET AOORESS, CITY, STATE, ZIP COOE	
				100	FRANCIS MARION LANE, PO BOX 880	•
FRANCIS	MARION MANOR H	EALTH & REHABILITATION		MA	RION, VA 24354	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	·	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE COMPLETION
F 333	mobility and toilet us assistance of two proffunit, dressing, portion of unit, dressing, and unit, dressing, portion of unit, dressing, portion of unit, dressing, and unit, dressing, portion of unit, dressing, dre	istance of 2 people for bed se and required total eople for transfers, locomotion ersonal hygiene and bathing. Thensive care plan for hitiated 12/6/16 for diabetes 12/23/16. Intervention/tasks dication as ordered by doctor, cation administration record).	F 3	33		
	251-300=6 units, 30 units, 401-450=12 u should be on insulin	1-350=8 units, 351-400=10 nits, All documentation documentation sheet."				
	The 2/3/17 0735 blo correctional insulin a	od sugar was 205. The administered was 2 units. I have received 4 units.				
	264. The correction	1:14 p.m.) blood sugar was al insulin documented was 4 should have received 6 units.				

FORM CMS-2567(02-99) Previous Versions Obsolete

The 2/24/17 0749 blood sugar was 179. The

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 53 of 67

MAR 3 0 2017 VOH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING		С
		495384	B. WING			03/02/2017
	ROVIDER OR SUPPLIER MARION MANOR HI	EALTH & REHABILITATION		100 FI	ET ADDRESS, CITY, STATE. ZIP CODE RANCIS MARION LANE, PO BOX 880 ION, VA 24354	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 387	#12 should have be the surveyor review with the director of 3:00 p.m. The DOI evidence Resident correct amount of it documentation. The surveyor inform the above concern meeting on 3/1/17 and with conference on 483.30(c)(1)(2) FRI PHYSICIAN VISIT (c) Frequency of Plant (1) The residents on least once every 30 admission, and at 1 (2) A physician visit occurs not later that visit was required. This REQUIREMED by: Based on staff intereview, the facility services with the service of the surveyor review with the surveyor review with the surveyor review.	administered was 0. Resident een administered 2 units. wed the blood sugar results nursing (DON) on 3/1/17 at N acknowledged there was no #12 was administered the nsulin based on the med the administrative staff of during the end of the day at 5:10 p.m. ion was provided prior to the 3/2/17. EQUENCY & TIMELINESS OF hysician Visits must be seen by a physician at 0 days for the first 90 days after east once every 60 thereafter. It is considered timely if it an 10 days after the date the NT is not met as evidenced erview and clinical record staff failed to ensure timely 1 of 24 Residents in the survey	F	333	F387 Ensuring timely physician for all residents is a priority the team at FMM 1. Resident #4 was evaluated the physician during her first third 30 day period. There appears to have been no ill effects from not being seen the physician during her see 30 day period. 2. All residents have the potential to be affected by	ted by rst and h by cond
	The findings includ				same practice.	
	Resident #4 was a	admitted to the facility on			Conti	inued

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PR)NTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	(S FOR WEDICARE	A MEDICAID SELVICES				1
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CDNSTRUCTION	(X3) DATE SURVEY COMPLETED
		105004	- IA/INIC	_		C 02/02/2017
		495384	B. WING			03/02/2017
NAME OF F	PROVIDER OR SUPPLIER		ļ		REET ADDRESS, CITY, STATE, ZIP CODE	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION		1	FRANCIS MARION LANE, PO BOX 880 ARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN DF CDRRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION
F 387	Continued From pa		F;	387	Continued	
	3/14/16 with the foll limited to anemia, a disease, high blood dementia, and hepa change MDS (Minir (Assessment Refer resident was coded Interview for Menta protocol) of 00 out of Resident #4 was all dependent on 2 sta personal hygiene at During the clinical renoted by the survey progress note that of clinical record. The for 3/14/16 and the clinical record was compared to make the clinical record was administrative team documented finding	llowing diagnoses of, but not atrial fibrillation, coronary heart of pressure, diabetes, stroke, atic failure. On the significant mum Data Set) with an ARD rence Date) of 12/19/16, the das having a BIMS (Brief al Status, an assessment of a possible score of 15. Iso coded as being totally aff members for dressing, and bathing. Tecord review on 3/1/17, it was yor that there was one could not be found in the ere was a progress note dated a next progress note in the dated for 5/12/16. Iximately 5:15pm, the next was notified of the above gs by the surveyor.			3. Re-educated team and physicians regarding the requivisit schedule. Beginning in April, a Nurse Practitioner with be on site three days weekly thassist in ensuring residents are evaluated as required or needed. The RN Nurse Manager (DON) or designee will audit monthly x 6 months. Data will reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	iil to e ed.
	On 3/2/17 at approx nursing returned to missed the progres	ximately 10 am, the director of the surveyor and stated, "We as note for April."				
F 456 SS=D´	surveyor prior to the 483.90(d)(2)(e) ESS OPERATING CONI	ion was provided to the e exit conference on 3/1/17. SENTIAL EQUIPMENT, SAFE DITION nechanical, electrical, and	F۷	456	F456 Ensuring temperatures are checked daily on the hydrocollators in the rehab	
		nechanical, electrical, and nent in safe operating			department is a priority for team at FMM	the
	(e) Resident Rooms	s			Continue	ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility ID: VA0086

If continuation sheel Page 55 of 67

MAR 3 0 2017
MOH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-		Ol	<u>VIB NO.</u>	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		ONSTRUCTION		SURVEY PLETED
		495384	B. WING			03/0) 2/20 17 ·
	ROVIDER OR SUPPLIER	EALTH & REHABILITATION	:	100 F	ET ADDRESS. CITY, STATE, ZIP CDDE RANCIS MARION LANE, PO BOX 880 ION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456	Continued From pa Resident rooms mu for adequate nursin residents.	ge 55 ust be designed and equipped ng care, comfort, and privacy of	F 4	56	Continued		
	This REQUIREMENT by: Based on observation and staff interview, ensure temperature hydrocollators in the The findings included The surveyor and the registered nurse #1 department on 3/2/was informed that the hot pack hydrocollator. The temperatures for the obtained. The rehallows	ne quality assurance toured the rehabilitation 17 at 10:30 a.m. The surveyor he rehab department had a tor and a cold pack surveyor asked if e hydrocollators were o manager licensed physical			 No residents were affect the deficient practice. All residents have the potential to be affected by same practice. Educated team members regarding the requirement check and log temperature to ensure they are within appropriate range and contable Bio-med if out of range. 	the s to s daily	
	therapy assistant st usually checked we The rehab manage temperatures of the didn't always record The surveyor review 2017. The January recorded temperatu 1/13/17, 1/21/17, ar temperatures recor- hydrocollator. Ther temperatures for the The February 2017 temperature log had (2/3/17, 2/18/17, 2/2 2/28/17). There we	ated temperatures were sekly maybe twice a week. It stated he looked at the se hydrocollators every day but at them. I them. I them temperature log for 2017 temperature log had lires for 4 dates (1/4/17, and 1/27/17). These were ded for the hot pack			 4. The Administrator or dewill audit 4x monthly x 6 months. Data will be reporthe QAPI team. 5. Corrective action will be complete by 04/14/17. 	ted to	

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	42 FOR MEDICARE	S MEDICAID SERVICES		,	OND NO. 0930-039 I
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495384	B. WING		03/02/2017
NAME OF I	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP C	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION		100 FRANCIS MARION LANE, PO BO MARION, VA 24354	OX 880
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
F 456	no documentation to temperatures were February 2017 infer that the hydrocollat checked weekly, cleaned weekly, us soiled. The date or week the hydrocollat checked. The log frompleted before to the surveyor requesting maintaining the hydrocollation. The QA RN storal different rehabitions and the temperature of the QA RN informed p.m. that the facility	ol Log for January 2017 had that the hydrocollators' checked or cleaned. The ction control log had checks ors' temperatures were eaned monthly, exterior ed covers washed weekly or if in the log was 2/6/17 that each ators' temperatures were or February 2017 was the month had ended. Setted the facility policy on procollator from the quality ed nurse on 3/2/17 at 11:10 tated the facility had switched elitation company; however, QA the eratures of the hydrocollators every day.		456	
F 502 SS=D	of frozen packs but surveyor requested of the hydrocollator. The surveyor inform the above concern 12:20 p.m. No further informati prior to the exit contable 483.50(a)(1) ADMIN (a) Laboratory Serv (1) The facility must	nothing about hot packs. The the facility policy on the care s again. ned the administrative staff of in a meeting on 3/2/17 at on or policies were provided ference on 3/2/17. NISTRATION	F 5	502	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 57 of 67



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		_	0	MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405004	D WINC			C
		495384	B. WING		PEET ADDRESS OFFY STATE 7/D CODE	03/02/2017
•	PROVIDER OR SUPPLIER	EALTH & REHABILITATION	:	İ	REET ADDRESS, CITY, STATE, ZIP CODE FRANCIS MARION LANE, PO BOX 880	
FRANCI	S WARION WANOR TH	ALTH & REHABIETATION		MA	RION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 502	of the services. This REQUIREMENT by: Based on staff intereview, the facility sordered labs for 3 or sample (Resident #2) The findings include 1. The facility sophysician ordered labs Resident #2 was accepted with the following limited to anemia, however, and chronic obstructive hyponatremia and how was coded on the Man ARD (Assessment tool us possible score of 15 coded as supervision dressing and requiring personal hygiene. The surveyor conductive hyponatremia and how with a BIMS (Brief lines assessment tool us possible score of 15 coded as supervision dressing and requiring personal hygiene.	e for the quality and timeliness NT is not met as evidenced rview and clinical record taff failed to obtain a physician f 18 Residents in the survey #2, #12 and #3). ed: taff failed to obtain a ab for Resident #2. Imitted to the facility on owing diagnoses of, but not igh blood pressure, heart xiety disorder, depression,	F	502	F502 Obtaining physician order is a priority for the team 1. Lab orders for resider #12 and #14 were clarificated the physician and new or obtained as needed. 2. All residents have the potential to be affected be same practice. 3. A new lab management process was developed a tracking tool initiated. Exprovided to team and with reinforced during the skilled the same process was developed as tracking tool initiated. Exprovided to team and with reinforced during the skilled the Nurse Manager of designee will audit 5x will be repossed to the provided to team and with reinforced during the skilled the Nurse Manager of the Nurse Manag	at FMM ats #2, ed with cders by the at the continuation of the
	this review, the surv the physician wrote check urinalysis." The surveyor could	eyor noted that on 11/15/16, an order which stated "may not locate the results of the ordered by the physician on			5. Corrective action will complete by 04/14/17.	l be

11/15/16.

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILE		CONSTRUCTION		ATE SURVEY OMPLETEO
				_			С
		495384	B. WING			0:	3/02/2017
NAME OF F	PROVIOER OR SUPPLIER		.	STF	REET AOORESS, CITY, STATE, ZIP COOE		
				100	FRANCIS MARION LANE, PO BOX 88	0	
FRANCIS	MARION MANOR HI	EALTH & REHABILITATION		MA	ARION, VA 24354		
(X41 ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ILO BE	(X5) COMPLETION DATE
F 502	administrative team documented finding. The administrative above documented 3/1/17 at approximations approximation of the surveyor prior to the 2. The facility staff ordered laboratory of the clinical record of 2/28/17 and 3/1/17. To the facility 5/8/15 but not limited to left tract infection, diabovascular dementia, hearing. Resident #12's quark (MDS) assessment reference date (ARI resident with a cognof 15 and without and delirium, psychosis, others. Section G aneed extensive assimbility and toilet us assistance of two per off unit, dressing, per Resident #12 was a bowel frequently.	eximately 5:15 pm, the was notified of the above gs. Iteam was again notified of the findings by the surveyor on ately 12 noon. Iteam was provided to the exit conference on 3/1/17. If alled to obtain a physician test for Resident #12. If Resident #12 was reviewed Resident #12 was admitted with diagnoses that included it humeral fracture, urinary etes mellitus, hypertension, pacemaker, and hard of the exit of 12/23/16 assessed the nitive summary score of 6 out my signs or symptoms of or behaviors directed toward assessed Resident #12 to istance of 2 people for bed se and required total explicitly exit in the symptomic of transfers, locomotion ersonal hygiene and bathing. It is dated 6/7/16 read in part "1.	F	502			
	Heme stool x 1 re:					•	

FORM CMS-2567(02-99) Previous Versions Obsolete

The surveyor reviewed the laboratory section of

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 59 of 67

MAR 30 2017 VDH/OLC

HUMAN SERVICES

PRINTED: 03/22/2017 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					0. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(Y2) MI II	TIPI F C	ONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONO THOU THE REAL PROPERTY OF THE PROPERTY OF	COI	MPLETED C
		495384	B. WING	_			_
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS. CITY, STATE. ZIP COI FRANCIS MARION LANE, PO BO	O3/02/2017 CODE BOX 880 ORRECTION ON SHOULD BE HE APPROPRIATE OATE	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION			RION, VA 24354		1461
(X4) ID PREFIX TAG	(CACIL DESIGNENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION
<u>.</u>	results. On 2/28/17 at 3:30 QA RN that the reson 6/7/16 were not The surveyor informathe physician order 6/7/16 and unable laboratory test in the 3/1/17 at 5:10 p.m. QA RN stated to the p.m. that the surveresults of the lab test conference on 3. The facility staff ordered laboratory count) and CMP (opanel) lab test for Resident #3 was a with diagnoses that high blood pressure diabetes, and hyperon and sessessment refacility staff assessment refacility staff assessment to insually under the control of the most recent and to insually under the control of the most recent and to insually under the control of the most recent and to insually under the control of	p.m., the surveyor informed ults of the heme stool ordered found in the clinical record. med the administrative staff of for heme stool ordered on to locate the results of that he end of the day meeting on essurveyor on 3/2/17 at 12:20 eyor wouldn't be finding the est. "It wasn't done." tion was provided prior to the 3/2/17. failed to obtain physician rests a CBC (complete blood comprehensive metabolic Resident #14. Idmitted to the facility 12/15/11 at included but not limited to re, heart failure, anxiety,		502			
	record revealed th	ew of Resident #3's clinical nat the physician had given an , for a CBC and CMP every 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

months.

Event 1D: 4K7211

Facility ID: VA0086

If continuation sheet Page 60 of 67



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			INTERIOR INTERIOR	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			COMPLETEO
ANO PLAN OF	CORRECTION	IDENTIFICATION NOMBER	A. BUILOING			c
		495384	B. WING			03/02/2017
14345 OS D	ROVIDER OR SUPPLIER				T AOORESS, CITY, STATE, ZIP COOE	
					ANCIS MARION LANE, PO BOX 880	
FRANCIS	MARION MANOR H	EALTH & REHABILITATION		MARI	ON, VA 24354	
(X4) IO PREFIX TAG	(EACH DESIGIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLETION
F 502	Continued From pa	age 60	F	502	V	
	clinical record reve	oratory reports in Resident #3's aled no results for the months except for December				
	On 3/1/16 at 3:35 p asked to assist with She said she would	om, the corporate nurse was in locating the missing lab test. id check.				·
	On 3/1/17, during a administrator, corp nurses were inform CMP laboratory tes	orate nurse and director of ned of the missing CBC and				
	On 3/2/17 at 12:00 informed the surve off."	pm the corporate nurse yor "somehow the nurses got				
F 514 S S =E	again discussed w director of nurses a	/17, the above information was ith the administrator, the and other administration staff. S PLETE/ACCURATE/ACCESSIB		514	F514 Ensuring a complete and a clinical record for all residuation a priority for the team at I	dents is
	standards and pra	with accepted professional ctices, the facility must records on each resident that			1. Resident #2's physicia notified and orders clarificates Residents #14, 13, 11 and experienced no ill effects	n was ed. 1
	(ii) Accurately doc	umented:			result of the practice.	
	(II) Accurately doc	umontou,			Cont	inued
	(iii) Readily access	sible; and			Cont	mueu

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO:4K7211

Facility IO: VA0086

If continuation sheet Page 61 of 67

MAR 3 0 2017 VOH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			AO.	IB NO.	0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES		DIFC		(X3) DATE	SURVEY
CTATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG	·		PLETED
		495384	B. WING _			03/	02/2017
		1,000	<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	The second second			FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR H	EALTH & REHABILITATION		MA	RION, VA 24354		[X5]
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION OATE
F 514	Continued From p	age 61	F 5	14	Continued		
	(iv) Systematically	organized			2 A 11: Jamé- 1 tha		
	(5) The medical re	cord must contain-			2. All residents have the	2	
					potential to be affected by the	e	
	(i) Sufficient inforn	nation to identify the resident;			same practice.		
		resident's assessments;			3. Education will be provided		
	(iii) The comprehe	ensive plan of care and services	3		regarding the lab tracking too		
	provided;				education provided to physic		
	(iv) The results of	any preadmission screening ew evaluations and			by letter and 1:1 during surve and education provided regar		
	determinations co	onducted by the State,			med pass and appropriate documentation.		
	(v) Physician's, no professional's pro	urse's, and other licensed ogress notes; and			4. The Nurse Manager or		
	services reports and This REQUIREM	adiology and other diagnostic as required under §483.50. IENT is not met as evidenced			designee will audit for accur of complete medical record : weekly x 12 weeks and 10 x	5x	
	Based on staff in review, the facility	nterview and clinical record y staff failed to ensure a curate clinical record for 5 of 24 survey sample (Resident #2,	ı		monthly for 6 months. Data be reported to the QAPI tear		
	#14, #13, #11, aı	nd #1).			5. Corrective action will be complete by 04/14/17.		
	The findings incl						
	complete and ac Resident #2.	y staff failed to ensure a ccurate clinical record for					
	0107116 with the	s admitted to the facility on following diagnoses of, but not a, high blood pressure, heart					

FORM CMS-2567(02-99) Previous Versions Obsolete

failure, diabetes, anxiety disorder, depression,

chronic obstructive pulmonary disease,

Event ID: 4K7211

Facility ID: VA0086

If conlinuation sheet Page 62 of 67

MAR 3 0 2017 VOH/OLC

AND HIMAN SERVICES

PRINTED: 03/22/2017 FORM APPROVED

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
CENTERS FOR MEDICARE	& MEDICAID SERVICES	00011117	TIPLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 -	NG	COMPLETED
	495384	B. WING		03/02/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 8	80
FRANCIS MARION MANOR HI	EALTH & REHABILITATION		MARION, VA 24354	
\^~\'\'\'\'\\\\\\\\\\\\\\\\\\\\\\\\\\\\	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CDRREC X (EACH CDRRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETION
was coded on the an ARD (Assessming ARD) (Assessming ARD) (Brief assessment too) upossible score of 1 coded as supervisional dressing and requipersonal hygiene. The surveyor concording the review physician had orderevery 3 months or found results of the paper clinical recording and September, 2 The administrative surveyor of the about 3/1/17 at approximation conference room. On 3/2/17 at 10 a brought copies of June and September, and	hyperkalemia. The resident MDS (Minimum Data Set) with ent Reference Date) of 2/27/17 Interview for Mental Status, an sed) with a score of 14 out of a 5. Resident #2 was also ion of 1 staff member for iring limited assistance with ducted a clinical record review hart on 3/1/17. If the surveyor noted that the ered a Hgb A1C To be drawn a Resident #2. The surveyor e Hgb A1C for 12/8/16 in the ord. The months of June, 2016 016 were not in the paper charted the ered and was notified by the love documented findings on nately 5:20 pm in the	t.	514	

these results to me."

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

2. The facility staff failed to ensure a

PRINTED: 03/22/2017 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(VO) MIII 7	TIPLE CO	NSTRUCTION	(X3) OA	E SURVEY
STATEMENT	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:				CON	MPLETEO .
	·	495384	B. WING				/02/2017
NAME OF P	ROVIOER OR SUPPLIER	10000	<u>' T</u>		ET AOORESS, CITY, STATE, ZIP COO		
		- ALTH A DEHABILITATION			RANCIS MARION LANE, PO BO	K 880	
FRANCIS		EALTH & REHABILITATION	1	MAR	ION, VA 24354 PROVIDER'S PLAN OF CORR	ECTION	ĮX5Į
(X4) IO PREFIX TAG	TAOU OFFICIENCS	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE	COMPLETION DATE
			F :	514			
F 514	Continued From pa	age 63	, ,	,,,			
	Resident #14.						
	11/15/16 with the filmited to high bloc constipation, atrial edema. The resid MDS (Minimum Da (Assessment Referequiring extensive for eating and perswas also coded as staff member for block as the staff member for block and the staff member for block as the staff member for block and the staff member for block as the staff member for block and the staff member for block						
	of Resident #14's During this review were two physicia	ducted a clinical record review medical record on 3/2/17. the surveyor noted that there n progress notes in the paper t did not include the date the ere made nor were the progressician.	S				
	documented findit	e team was notified of the abovings on 3/2/17 at approximately onference room by the surveyo					
	No further informa surveyor prior to t	ation was provided to the he exit conference on 3/2/17.					
,	3. The facility complete and acc Resident #13.	staff failed to maintain a curate medical record for					
	4/7/15 with the fo limited to heart fa	s readmitted to the facility on llowing diagnoses of, but not lilure, high blood pressure, ler, multiple sclerosis, seizure r stass ulcer to right lower					

FORM CMS-2567(02-99) Previous Versions Obsolete

extremity, depression and chronic obstructive Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 64 of 67

MAR 30 2017 VOH/OLC

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED
		495384	B. WING			.C 03/02/2017
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION			STREET ADDRESS, CITY, STAT 100 FRANCIS MARION LAND MARION, VA 24354			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
F 514	the quarterly MDS (ARD (Assessment as having a BIMS (Status, an assessm of a possible score coded as requiring member for eating being totally dependent of Resident #13's in The surveyor performation of Resident #13's in The surveyor found physician progress the physician nor with edate of the physician nor with edat	The resident was coded on (Minimum Data Set) with an Reference Date) of 12/28/16 Brief Interview for Mental nent protocol) score of 15 out of 15. Resident #13 is also extensive assistance of 1 staff and personal hygiene and dent on 2 or more staffing and bathing. The admittance of 1 staff and personal hygiene and dent on 2 or more staffing and bathing. The admittance were three notes that were not signed by as the progress note dated for sician visit. The admittance of the exit conference on 3/1/17 at we documented findings by the exit conference on 3/2/17. If alled to ensure a complete lary 2017 medication rd (MAR) for Resident #11. The resident #11 was reviewed. Resident #11 was admitted readmitted 2/13/17 and loses that included but not ia, sepsis, chronic obstructive, anxiety, chronic pain, late lumbar compression and disease, chronic steroid gastroesophageal reflux emia, seizures, right eye		514		

FDRM CMS-2567(02-99) Previous Versions Obsolete

Even) ID: 4K7211

Facility ID: VA0086

If continuation sheet Page 65 of 67

RECEIVED
MAR 3 0 2017
VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED

OFNITEDO FOD MEDICAD	E & MEDICAID SERVICES				OMB NO. 0	938-0391
CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUI	TIPLE C	ONSTRUCTION	(X3) OATE S	SURVEY
ANO PLAN OF CORRECTION	IOENTIFICATION NUMBER:	A. BUILC	ING		C	LILO
	495384	B. WING	·			2/2017
NAME OF PROVIOER OR SUPPLIES	3			ET AOORESS, CITY, STATE, ZIP COOE		
FRANCIS MARION MANOR I	HEALTH & REHABILITATION			RANCIS MARION LANE, PO BOX 88 RION, VA 24354		<u></u>
PREFIX (EACH DEFICIENT	TATEMENT OF OEFICIENCIES OF MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE ((X5) COMPLETION OATE
F 514 Continued From p	age 65	F :	514			
(MDS) assessment reference date (Al resident with a copy of 15 in Section Contained "holes", documentation that been given. On 2/27/17 at bed the administration Atorvastin, Budes Oxycontin, Gabap (midnight dose), at the surveyor information the survey meeting. No further information exit conference or 5. The facility staff drops were document of the facility sta	rmed the administrative staff of ment when medications were he February 2017 in the end of g on 3/2/17 at 12:20 p.m. ation was provided prior to the a 3/2/17. If ailed to ensure polytrim eye nented. If of Resident #1 was reviewed an 1/19/17. Resident #6 was cility on 12/14/11 with diagnoses were not limited to: anxiety, high astroesophageal reflux,	6				

FORM CMS-2567(02-99) Previous Versions Obsolete

set) assessment, with an ARD (assessment reference date) of 12/7/16 was reviewed. Section C (cognitive patterns) of this assessment coded

Event IO: 4K7211

Facility IO: VA0086

If continuation sheet Page 66 of 67

MAR 30 2017 VOH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE: COMPL A. BUILDING C. C. O3/02 NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 66 the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to	4PPROVE 0938-039	FURM APP MB NO. 093					MEDICAID SERVICES	RS FOR MEDICARE	CENTER
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 66 The resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to	SURVEY	(X3) DATE SUF	(X3) I	NSTRUCTION				T OF DEFICIENCIES OF CORRECTION	STATEMENT AND PLAN C
FRANCIS MARION MANOR HEALTH & REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 66 The resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to		03/02/2		~	·	B. WING	495384		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 66 F 514 the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to				TADDRESS, CITY, STATE, ZIP CODE	STREET ADDR			PROVIDER OR SUPPLIER	NAME OF F
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 66 the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to			X 880				LTH & REHABILITATION	S MARION MANOR HE	FRANCIS
the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to	(X5) COMPLETION DATE	BE COM	SHOULD BE	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	(EAC	PREFIX	JST BE PRECEDED BY FULL	(EACH DEFICIENCY	PREFIX
sometimes understand and to usually be understood. Resident #1's clinical record was reviewed on 3/1/17. Her physician's orders revealed an order for Polytrim eye drops 2 drops to left eye 4 x daily x1 week. The surveyor also reviewed the residents medication administration record (MAR). The medication polytrim was started on 2/20/17 at 2100. On 2/21/17 at 2100 the nurse had circled this area and written on the back of the MAR that the resident had refused the eye drops. However, on 2/23/17 at 2100 no recording was found indicating the medication had been administered. On 2/27/17 at 1400 and at 2100 there was no documentation. ON 3/1/17, LPN #3 was asked if she had administered the eye drops. After looking at the MAR she stated, "I don't know why I didn't initial there, I gave the medication." The surveyor informed the administrator and other administrative staff of the medication documentation issue during the end of the day meeting on 3/1/17 at 5:10 p.m. No further information was provided prior to the exit conference on 3/2/17.					14	F 5	nort and long term memory impaired decision making. In the was coded to did and to usually be secord was reviewed on corders revealed an order 2 drops to left eye 4 x daily ralso reviewed the dministration record in polytrim was started on 21/17 at 2100 the nurse and written on the back of ent had refused the eye 23/17 at 2100 no recording e medication had been 17 at 1400 and at 2100 tation. It is asked if she had rops. After looking at the 1't know why I didn't initial ation."	the resident to have problems with sever In section B, the res sometimes understa understood. Resident #1's clinica 3/1/17. Her physicia for Polytrim eye drop x1 week. The surve residents medication (MAR). The medicat 2/20/17 at 2100. On had circled this area the MAR that the residents However, on was found indicating administered. On 2/2 there was no documed ON 3/1/17, LPN #3 vadministered the eye MAR she stated, "I dithere, I gave the medication of the surveyor information in the surveyor informatio	

State of Virginia	*		·	FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1X11 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LE CONSTRUCTION	'X3; DATE SURVEY COMPLETED
	VA0086	B WING		03/02/2017
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE. ZIP CODE	1 00/02/2017
FRANCIS MARION MANOR H	IEALTH & REHARI 100 FRA		N LANE, PO BOX 880	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.RE COURTER
F 001 Non Compliance		F 001	Ensuring compliance with	the
The facility was out	of compliance with the		following Virginia Rules a	nd
following state licer	sure requirements:		Regulations for the Licens	ure of
This RULE: is not a	met as evidenced by:		Nursing Facilities is a prior	rity for
The facility was not	in compliance with the		the team at FMM.	101
following Virginia Ri Licensure of Nursin	ules and Regulations for the			
	y raciilles:		Clinical Records:	
Clinical Records	. =.		Cross reference F164 and I	⁷ 514
and F514	B. E)- cross reference to F164		to 12VAC5-371-360 (B.E)	
Nursing Services			Nursing Services:	
12VAC5-371-220 (B	. C)-cross reference to F241,		Cross reference F241, F309),
F309, F314, F328, F	322 and F333		F314, F328, F322 and F333	to
Maintenance and Ho	ousekeeping)-cross reference to F252		12VAC5-371-220 (B.C)	
and F456	oross reference to F252		Maintenance and Housekee	nina:
Posidont Aggregation	410		Cross reference F252 and F	456
Resident Assessmer 12VAC5-371-250 (A. F272, F278 and F28	4. C. F)-cross reference to		to 12VAC5-371-370 (A)	
Physician Carrier			Resident Assessment and Ca	are
Physician Services 12VAC5-371-240-cro	ss reference to F387		Planning: Cross reference F	272
			F278 and F280 to 12VAC5-	371-
Diagnostic Services 12VAC5-371-310 (A)	-cross reference to F502.		250 (A.4 C. F)	
			Physician Services:	
			Cross reference F387 to	
			12VAC5-371-240	
			Diagnostic Services:	
			Cross reference F502 to	
			12VAC5-371-310(A)	

Administrator

Mar 30 2017