PRINTED: 05/16/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. MNG 495384 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET ON REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY E 000 Initial Comments E 000 An unannounced Emergency Preparedness survey was conducted 04/24/18 through 04/26/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey. F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 04/24/18 through \*Please note, Francis Marion Manor 04/26/18. Corrections are required for is licensed for 109 beds, instead of compliance with 42 CFR Part 483 Federal Long 110. Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 89 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 2 F578 closed record reviews Complete documentation of residents F 578 Request/Refuse/Dscntnue Trmnt: Formite Adv Dir F 578 wishes for DNR status is important to the SS=E CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) team at Francis Marion Manor. §483.10(c)(6) The right to request, refuse, and/or 1. All residents found to have been discontinue treatment, to participate in or refuse affected by the deficient practice to participate in experimental research, and to have been reviewed. #62 has a formulate an advance directive. signed DNR, physician failed to date and time the order - he will complete §483.10(c)(8) Nothing in this paragraph should be the order during his next visit. #75 construed as the right of the resident to receive received a new DNR form, completed the provision of medical treatment or medical on 4/25/18. #63 new DNR form services deemed medically unnecessary or completed 5/17/18. #288 received a inappropriate. new DNR form completed 5/17/18. #12 DNR added to the monthly orders §483,10(a)(12) The facility must comply with the 5/17/18. requirements specified in 42 CFR part 489.

(i) These requirements include provisions to LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

subpart I (Advance Directives)

TITLE (duinistrator

(F578 continued)

X6 CATE

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days. following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<u>_</u>		495384	B. WING_		04/26/2018
	NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP (100 FRANCIS MARION LANE, PO BI MARION, VA 24354	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 578	residents concerning medical or surgical tresident's option, for (ii) This includes a w facility's policies to in and applicable State (iii) Facilities are perfentities to furnish this legally responsible for requirements of this (iv) If an adult individ time of admission an information or articul has executed an advancy give advance di individual's resident with State Law.  (v) The facility is not provide this information or she is able to recefollow-up procedure the information to the appropriate time. This REQUIREMENT by:  Based on staff intervand facility document to ensure a complete 21 residents in the su #62. #75. #63, #288  The findings included	written information to all adult g the right to accept or refuse treatment and, at the remulate an advance directive. Written description of the implement advance directives e law.  I mitted to contract with other is information but are still for ensuring that the section are met. I dual is incapacitated at the indiction and is unable to receive late whether or not he or she wance directive, the facility irective information to the representative in accordance in relieved of its obligation to tion to the individual once he eindividual directly at the individual directly at the individual directly at the individual directly staff failed the and accurate DNR for 5 of survey sample (Residents and #12).	F 5	2. A complete audit of all will be conducted to ensuall Advance Directive for required code status is in Physician Order Sheet.  3. Education will be provided to address code statupon admission (including The Shift Leader will do a admissions to ensure code addressed. Education with care plan team for the Softhe Asst. Nurse Manager status quarterly, with signannually to validate code  4. All new admissions with ensure code status is addition of wishes is additionally to the validation of the validation of wishes is additionally to the presented to QAPI for 5. Corrective action will be by 5/31/18.	ure completion of the and to ensure included in the vided to the nursing atus completely ing form and orders), audits of all new de status is vill be provided to the ocial Worker and/or into re-address code inficant changes and e status.  Till be audited to dressed. Records are plan meetings to e forms and to ensure ddressed in the care sults of the audits will in further direction.
	#62.	citate) order for Resident			

Resident #62 was readmitted to the facility on 3/23/18 with the following diagnoses of, but not



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CENTERS FOR MEDICAR	OMB NO. 0938-03		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495384	B. WING	04/26/2018
NAME OF PROVIDER OR SUPPLIER		STRFET ADDRESS, CITY, STATE, ZIF	CODE

FRANCIS MARION MANOR HEALTH & REHABILITATION

100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**)

(X5) COMPLETION

F 578 Continued From page 2

limited to high blood pressure, Peripheral Vascular Disease. Obstructive Uropathy. Pneumonia, diabetes, anxiety disorder. depression and respiratory failure. On the significant change, MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/1/18 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. Resident #62 was also coded as being totally dependent on 2 or more staff members for bathing, personal hygiene and bathing...

The surveyor conducted a clinical record review of Resident #62 on 4/26/18. During this review, it was noted by the surveyor that the DNR was not dated nor timed by the physician.

On 4/26/18 at 4:04 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 4/26/18.

The facility failed to have a complete and accurate DDNR (Durable Do Not Resuscitate) for Resident #75.

Resident #75 was admitted to the facility on 6/5/15 with the following diagnoses of, but not limited to dementia, Parkinson's Disease, depression, Schizophrenia and psychotic disorder. On the significant change, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/9/18 the resident was coded as having short term and long-term memory problems with being severely impaired in making daily decisions. Resident #75 was also coded as

F 578

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Event ID. ILEG\*1

Facility (D. VAC086

If continuation sheet Page 3 of 46



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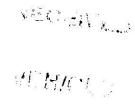
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. 'MING		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION	200000000	FRANCIS MARION LANE, PO BOX 880 RION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 578	for personal hygiene totally dependent on The surveyor condu on Resident #75 on was noted by the su for 1/22/18 was not 1 of the DDNR read check 1 or 2]:  1. The patient is Conformed decision 2. The patient is IN informed decision The boxes beside #75 Section 2 read "If yo	assistance of 1 staff member and dressing and being 1 staff member for bathing.  In the determinant of the staff member for bathing.  In the determinant of the staff member for bathing.  In the determinant of the staff member for bathing.  In the determinant of the staff member for bathing and the staff member for bathing.	F 578		
	4/25/18 at 5 pm in the above documented on 4/26/18 at 8 am, the surveyor with a condated for 4/25/18. The went ahead had a noise complete.  No further information surveyor prior to the 3. For Resident #63	d the administrative team on the conference room of the findings. The administrator provided copy of a DDNR that was the administrator stated. "We saw one filled out, which now it on was provided to the exit conference on 4/26/18, the facility staff failed to DNR (do not resuscitate)			



Resident #63 was admitted to the facility on 11/03/17. Diagnoses included but not limited to

anemia, heart failure, hypertension.





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		MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED	
		495384	B. WING		<u> </u>	04/26/2018
NAME OF PR	ROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
FRANCIS I	MARION MANOR HEALT	TH & REHABILITATION		1000000	00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
1		1				
F 578	Continued From page	e 4	F	578		
	hyperlipidemia, cereb dementia, depression chronic kidney diseas	provascular accident, n, atrial fibrillation and				
	an ARD (assessment	6 (minimum data set) with reference date) of 04/02/18 is 14 out of 15 in section C,				
	cognitive status. This	is a quarterly MDS.				
	04/25/18. It contained Orders" form which re	al record was reviewed on d an "Advance Directive ead as follows: es to be followed.				
	[] Advance Direc [] Respirato [] Bag/Mask [] Intubation	<				
		al Ventilation				
	[] Defibrillation	al cardiac massage on or cardioversion ogical treatment mias				
	[] No code No resuscita utilized. Maintain con	ative measures will be nfort measures.				

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Above orders:

checked on the form.

[] Per discussion with patient

The box beside of "no code" had been checked and the form had been signed and dated by the physician on 02/01/18. No other boxes had been

[] Per discussion with POA and/or family

Event ID: ILEG11

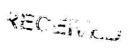
Facility ID, VAC086

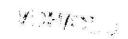
If continuation sheet Page 5 of 46



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<u>CENTER</u>	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO, 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP COD	
FRANCIS	MARION MANOR HEA	LTH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX : MARION, VA 24354	880
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
F 578	Continued From pag	ge 5	F:	578	
	Surveyor spoke with	the DON (director of			
		7 at approximately 1030			
	75 (57)	ent's DNR form. DON stated			
		they use, rather than the ilth form. The surveyor asked			
	The state of the s	e boxes under "above			
		e been checked and the DON			
	stated that it should	have been.			
	discussed with the a	ncomplete DNR form was			
	meeting on 04/25/16	3 at approximately 1640.			
	No further information	on was provided prior to exit.			
		8 the facility staff failed to			
	ensure a complete E	ONR form.			
		admitted to the facility on a sincluded but not limited to			
	7.57	n, thyroid disorder, dementia,			
		, bipolar disorder, psychotic			
	disorder, schizophre	nia and asthma.			
	The most recent MD	S with an ARD of 04/18/18			
		as 15 out of 15 in section C.			
	cognitive status. Thi	s is an admission MDS.			
18	Resident #288's clin	ical record was reviewed on			
		ed an "Advance Directive			
	Orders" form which	read as follows:			
		res to be followed.			
		ctives Evidence			
		ory Support			
	[] Bag/Mas [] Intubatio				
		cal Ventilation			
	[] iviechani	cai ventilation			





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		NO HOWAN SERVICES					FORM APPROVED
		MEDICAID SERVICES	<u> </u>	760		<u> </u>	B NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONST	TRUCTION		DATE SURVEY COMPLETED
		495384	B. WING _		- <u></u>		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET	ADDRESS, CITY STATE, ZIP CODE		V4,20,2010
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION			NCIS MARION LANE, PO BOX 88 N, VA 24354	10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	W 1000	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	Continued From page	e 6	, F.5	78			
	[] Cardiac Sup		10° 17 <del>5</del> 1	, ,			
		al cardiac massage					
		on or cardioversion					
	(6.74)	logical treatment					
	[] Arrhyth						
	[] Blood p						
	[] No code						
	21 • • 12 1 Person 1 Person 2 1 Person 2 1 Person 2 1 Person 2 Per	ative measures will be					
	utilized. Maintain com	ifort measures.					
	Above orders:						
		sion with patient					
	[] Per discuss	sion with POA and/or family					
		o code" had been checked					
		en signed and dated by the					
	physician on 04/12/18 checked on the form.	8. No other boxes had been					
	Surveyor spoke with t	the DON (director of					
		at approximately 1030					
		nt's DNR form. DON stated					
		ney use, rather than the					
		th form. The surveyor asked					
	the DON if one of the						
		been checked and the DON					
	stated that it should h	ave been.					
	The concern of the in-	complete DNR form was					
		lministrative team during a					
	meeting on 04/25/18	at approximately 1640.					
	No further information	n was provided prior to exit.					
	5. The facility staff fa	iled to ensure the April 2018					

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physician order sheet contained a physician order for the Advanced Directives Orders initially signed on 9/2/16 for Resident #12's "No Code" status.

Event ID "LEG1"

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
	200	495384	B. WING _			04/26/2018
	ROVIDER OR SUPPLIER  MARION MANOR HEAI	LTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 100 FRANCIS MARION LANE, PO BOX MARION, VA 24354	DDE	0 WESTER
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 578	Continued From pag	ge 7	, F.5	578		
	4/24/18 through 4/26 admitted to the facili included but not limit failure, osteoarthritis major depressive dispsychosis, dementia disturbances, anxiet arthritis. constipation hemiplegia/hemipare disease affecting unsussessment with an (ARD) of 2/5/18 asses BIMS of 9 out of 15. of delirium or behavilated.	without behavioral by disorder, rheumatoid ch. and cesis following cerebrovascular specified side.  Ital minimum data set (MDS) cassessment reference date cessed the resident with a Resident #12 had no signs cors but was assessed to	8			
	titled "Advanced Directives. Cardiac Sbox for "No Code" wwith an explanation (power of attorney) a physician on 9/2/16." April 2018 signed ph	cal record contained a form ectives Orders". The form theck for Advanced Support and No Code. The as marked for Resident #12 "Per discussion with POA and/or family signed by "The surveyor reviewed the hysician order sheet (POS) ocate a current physician				

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

order

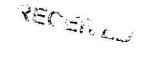
The surveyor interviewed registered nurse #1 on 4/25/18 at 2:30 p.m. about Resident #12's code status and no current physician order found on the April 2018 POS. R.N. #1 reviewed the clinical record and was unable to locate a physician

The surveyor informed the administrator and the

Event ID:ILEG\*1

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		MEDICAID SERVICES			FORM APPROVED
1.0 2		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495384	B. WING	- <u> </u>	04/26/2018
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354	T 34/20/20/10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 578	director of nursing of 4/25/18 at 4:42 p.m. policy on advanced diresuscitate). The addidoes not use the DNI (formerly known as the goldenrod color).  The surveyor reviewed Not Resuscitate (DDNR) read in part "VII. Pro 1. A DNR is a physicic Cardiopulmonary Resthe event of cardiac of Creating a DNR b. If agreed upon, the phy order not to resuscitate chart, iv. Document to the consent of the part consent on behalf of	the above concern on and requested the facility irectives/DNR (do not ministrator stated the facility R form from Virginia are golden because of the are (DNR) and Do Not Orders-Virginia". The policy cedure: A. DNRs Generally an order to withhold suscitation from a person in a person of a DNR is sician will: ii. Transcribe and the patient in the patient or person authorized to the patient in the patient tice to staff that a DNR has	F 578		
	No further information exit conference on 4/ Accuracy of Assessm CFR(s): 483.20(g)		F 641	F 641 Accurate assessments for residents at Francis Marion Manor is very importan team at FMM.	
	resident's status.	of Assessments accurately reflect the		The deficient practice was corrected the residents identified. #68 MDS was during the survey. #40 MDS was correduring the survey as well.  All MDS of residents receiving hosp	corrected ected

Based on staff interview and clinical record

accurate MDS (minimum data set) assessment for 2 of 21 Residents, Resident #68 and Resident

review the facility staff failed to ensure an

Facility ID: VA0086

were reviewed to ensure appropriate coding. All

(F 641 continued)

MDS were reviewed to ensure appropriate

coding of the Flu and Pneumonia vaccines

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CENTERO	OK WILDICAN	L & MILDICAID SERVICES		1,000	OMB NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384 B. WING		B. WING		
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	

# F 641 Continued From page 9 #40.

The findings included:

1. For Resident #68 the facility staff failed to accurately code that the Resident was receiving hospice services on the MDS.

Resident #68 was admitted to the facility on 05/3017. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, dementia, anxiety, depression, and respiratory failure.

The most recent MDS with an ARD (assessment reference date) of 04/06/18 coded the Resident as 13 of 15 in section C, cognitive status. Section O, special treatments, procedures and programs coded the Resident as having oxygen therapy while in the facility. No other areas were coded in this section. This is a significant change MDS.

Resident #68's clinical record was reviewed on 04/25/18. It contained a signed physician's order summary dated 04/08/18, which read in part "Admit to Hospice .....(name omitted)". The order date for this entry was 03/28/18.

The surveyor spoke with the MDS coordinator on 04/25/18 at approximately 1350 regarding the incorrectly coded MDS. The surveyor asked the MDS coordinator if hospice should have been coded on the MDS and the MDS coordinator stated "That is why we did the significant change MDS". The MDS coordinator provided the surveyor with a corrected copy of section O of the MDS on 04/25/18 at approximately 1410.

The concern of the incorrect MDS was discussed

#### F 641 F 641 continued

- 3. Education provided to MDS team to validate coding is correct for those two areas.
- 4. MDS nurse will verify appropriate coding with one other nurse in the MDS office prior to submission. An audit will be conducted by the Assistant Nurse Manager during the care plan process to ensure proper coding. Results will be reported to the QAPI team for further direction.
- 5. Corrective action will be completed by May 31, 2018.

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Event ID: ILEG11

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	L & MILDICAID SERVICES			OMB NO. 0938-039
DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	or mentione to the contract		(X3) DATE SURVEY COMPLETED
	495384	B WING		04/26/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	a Maria de
DION MANOR U	EALTH & DEHABILITATION		100 FRANCIS MARION LANE, PO BOX 880	
IRION MANOR HE	EALTH & REHABILITATION		MARION, VA 24354	
		ID PREEIX	PROVIDER'S PLAN OF CORRECT /FACH CORRECTIVE ACTION SHO	2020-0-2
		TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	
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#### F 641 Continued From page 10

with the administrative team during a meeting on 04/25/18 at approximately 1640.

No further information was provided prior to exit.

2. The facility staff failed to ensure an accurate MDS (Minimum Data Set) for Resident #40.

Resident #40 was admitted to the facility on 10/18/17 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, dementia, anxiety disorder, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/10/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #40 was also coded as requiring extensive assistance of 2 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on Resident #40. During this review, the surveyor noted that on the quarterly MDS with ARD of 3/10/18, Under Section O0250, the resident was coded as to have had received the flu vaccine in the facility for this year's flu session. The date of the vaccination was documented as being administrated on 7/13/17. The surveyor noted on the same MDS that the admission date to the facility was 10/18/17.

The surveyor notified the director of nursing (DON) on 4/25/18 at approximately 9:30 am of the above documented findings. The DON stated that she would look into this.

The DON provided copies of the quarterly MDS with ARD of 3/10/18 to the surveyor at 10:40 am.

F 641



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

PRINTED: 05/16/2018 FORM APPROVED

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED
		495384	B. WING		04/26/2018
NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
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F 641	Continued From page	÷ 11	F 641	***************************************	
	50 A TANAN AND AND AND ADDRESS OF THE ADDRESS OF TH	end of the day conference, ative team of the above at 5 pm.		*	
	No further information surveyor prior to the	n was provided to the exit conference on 4/26/18.			
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 656	F 656 Comprehensive Care Plans for each is important to the team at Francis M	ZASSA NC 20 SA
	implement a compred care plan for each resident rights set for §483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the reunder §483.10, including treatment under §483 (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASAI rationale in the resides	cility must develop and thensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive aprehensive care plan must a resident's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record.	Manor  elop and n-centered ent with the c)(2) and rable a resident's sychosocial prehensive are plan must  shed to attain racticable well-being as r \$483.40; and so be required but are not cise of rights o refuse  racialized acility will aresident #69 care plan has been updated for use of the antipsychotic medication and for wonitoring of the symptoms being treated.  2. All residents receiving an antipsychotic medication have been identified as having the same potential for deficient practice. Therefore, an audit of all resident records will be conducted to ensure the medication diagnosis corresponds with the diagnosis report list and care planned appropriately with behaviors being monitored.  3. Utilize a new assessment to monitor use of antipsycotic medications including: gradual dose reduction (attempts and outcomes), diagnosis, behaviors including frequency, harm to self or others, side effects of medications, new medical symptoms since GDR, non-pharmacological interventions, care plans and MD and Resident Representative nofication.		on and g treated.  hotic aving ice. cords will on nosis ately with  tor use of radual nes), ency, since

Facility ID. VA0086 If continuation sheet Page 12 of 46



PRINTED: 05/16/2018 FORM APPROVED OMB NO. 0938-0391

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F 656	desired outcomes. (B) The resident's ifuture discharge. Five whether the resident community was as local contact agence entities, for this pur (C) Discharge plan plan, as appropriat requirements set for section.  This REQUIREME by:  Based on staff interview the facility scomprehensive car #69).  1. For Resident #6 plan for use of antimonitoring of the santipsychotic mediant section antipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring of the santipsychotic mediant plan for use of antimonitoring antipsychotic mediant plan for use of antipsychotic plan for use of antipsychotic plan f	goals for admission and preference and potential for acilities must document int's desire to return to the sessed and any referrals to cles and/or other appropriate roose. In the comprehensive care equipose, in accordance with the both in paragraph (c) of this in paragraph (c) of this in paragraph (c) of this in paragraph (d) of this in paragraph (e) of this in paragraph (f) of this in the properties and clinical record staff failed to develop a replan for 1 of 21 (Resident in paragraph). The properties was referred to the cation and symptoms for which the cation was ordered.  If Resident # 69 received in the cation was ordered in the cation was ordered.  If Resident # 69 received in the cation was no record of behaviors to sychotic medication or of go for a resident taking	· F	3. (continued) Education proven pharmacist to report if there a diagnosis, if symptoms are not documented for which the metused and if there are not assert ensure effectiveness of the most and to validate completion of the area audits will be conducted four weeks and then monthly for each resident receiving an medication. They will also auther care plan addresses the machine to the QAPI team for the example of the audit will be presented to the QAPI team for the example.  5. Corrective action will be conducted to the QAPI.	are no supporting but being sedication is being sedication is being sements to nedication.  Agers will audit assessment. Sed weekly for for six months in antipsychotic adit to make sure requirements.

affecting others. The resident was assessed with

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F 656	Continued From page	e 13	F 656		
	wandering 1-3 of the		303		
	surveyor noted a phy quetiapine 50 mg giv bedtime for unspecifi Diagnosis Report liste Unspecified Dementi Disturbance.  The resident's Medic and Treatment Admir document monitoring	review on 4/26/18, the sician order 1/15/18 for e 1 tablet by mouth at ed dementia. The resident's ed Principal Diagnosis as a without Behavioral ation Administration Record histration Record did not of behaviors for which the eated with antipsychotic			
	symptoms the antips	he resident's nurse which ychotic medication was e nurse was unable to name			
	2/8/18. 3/15/18, and concern that there was for the use of an antij symptoms were docuthe antipsychotic med				
F 658	notified of the concer on 4/26/18.	d director of nursing were n during a summary meeting eet Professional Standards	F 658	F 658 Providing services which meet pro	fessional

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

SS=D CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans

Facility ID: VA0086

standards is important to the team at

(continued F 658)

Francis Marion Manor.

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

PRINTED: 05/16/2018
FORM APPROVED

OMB NO. 0938-0391

RUCTION
(X3) DATE SURVEY

CENTENS	TON MEDICAN	E & MEDICAID SERVICES			<u>OMB</u> NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING		04/26/2018
NAME OF PRO	VIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE ZIP CODE	
EDANCIS MA	SPION MANOR U	EALTH & REHABILITATION	10	0 FRANCIS MARION LANE, PO BOX 880	
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		The state of the s			

F 658

#### F 658 Continued From page 14

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow standards of professional practice for 1 of 21 residents (Resident #26). The facility staff failed to follow the five rights of medication administration during a medication pass on 9/13/17. Resident #26 received a second dose of 9:00 a.m. medications when the nurse failed to document the medications Resident #26 received initially.

#### The findings included:

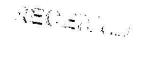
The facility staff failed to follow the five rights of medication administration for Resident #26 on 9/13/17. Resident #26 received double doses of Norvasc (given for hypertension), Aspirin (blood thinner), Plavix (used to prevent blood clots), Zyrtec (antihistamine), Chlorthalidone (diuretic). Glimepiride (used for type 2 diabetes mellitus). Klonopin (used for anxiety), Losartan (hypertension), Metoprolol (hypertension), and Paxil (used for depression) at 9:00 a.m. on 9/13/17.

Resident #26's clinical record was reviewed 4/24/18 through 4/26/18. Resident #26 was admitted to the facility 8/21/17 and readmitted 12/16/17 with diagnoses that included but not limited to cerebral hemorrhage, insomnia, dementia, diabetes mellitus type 2, hypertension, depression, hyperlipidemia, dyslipidemia, weakness, cerebrovascular accident, anxiety, and

#### Continued F 658

- 1. After discovering the medication error occured, the physician and resident representative were notified. The resident experienced no ill effects as a result of receiving the medications twice. Education was provided to the nurse in question.
- 2. Any resident receiving medication is at risk for the same deficient practice. Nurses will be re-educated regarding the five rights of medication administration
- 3. Licensed nursing team members will be re-educated regarding the five rights of medication administration.
- 4. Observation of medication passes to confirm the nurse practices the five rights of medication administration will be done weekly for eight weeks and then monthly for six months. The Nurse Manager or her designee will be responsible to perform the audits and to provide corrective measures during the audit as needed. Audit reports will be presented to the QAPI committee for further recommendations.
- 5. Corrective measures will be initiated by May 31, 2018.





when she realized there was an issue. The DON

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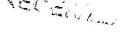
Facility ID: VA0086

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
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ED 441010			Ì	100 FRANCIS MARION LANE, F	O BOX 880	
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		MARION, VA 24354		
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F 658	Continued From page	± 15	F 6	58		
	gastroesophageal ref		, 0.			
	(MDS) assessment we reference date (ARD) resident with a BIMS status) of 2 out of 15. resident with altered I with behaviors that in that did not affect other assess the resident we of psychosis.  The surveyor reviewed notes from admission 4/25/18. The progress 09:40 read "Received (morning) medication upon taking over the meds (medications) withis being observed the round of 9am medical here at this time and error-vital signs obtain	of 2/23/18 assessed the (brief interview for mental The facility assessed the evel of consciousness and cluded verbal, physical and ers. The facility staff did not with any signs or symptoms and Resident #26's progress on 8/21/17 through as note dated 9/13/17 at a 2nd dose of 9am as from this nurse due to medication cart and 9am avere not signed off and with this nurse administered a 2nd tions-MD (medical doctor) notified of this med ned with results of 98.0 lse), 16 (respirations), BP				
	(DON) on 4/26/18 at 9/13/17 was a "fluke of charge nurse was do Resident #26 had red medications. The DO informed that her mot	wed the director of nursing 10:48 a.m. The DON stated day". The DON stated the ing the medication pass. served the 9:00 a.m. DN stated the nurse was ther was dying and the Illy left. The oncoming nurse				
	realized that she had 9:00 a.m. medications	given a 2nd dose of the s when the narcotic count The DON stated that's				





If continuation sheet Page 16 of 46

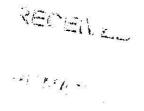
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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 658	2nd dose of 9:00 a.r stated the physician resident. The DON sign off the medicati Resident #26. The should have been si The surveyor asked facility's professional medication administ. The surveyor receive professional practice administration on 4/2 nurse #1 stated the professional practice administration was from Mosby's "Best Procedural Manual". Medication Administ 2. Right drug 3. Right	was here and informed of the m. medications. The DON order was to monitor the stated the first nurse didn't ons she had administered to DON stated the medications gned off as given.  the director of nursing for the I standard of practice for ration.  ed the facility's standard for a for medication 26/18. Corporate registered facility's standards of	F 658		
	director of nursing of 4/26/18 at 12:00 nod 4/26/18 at 12:00 nod No further information exit conference on 4 Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of care is a fapplies to all treatments.	ed the administrator and the fithe above concern on on.  on was provided prior to the /26/18.  care undamental principle that ent and care provided to	F 684	F 684 Providing Quality Care is importar team at Francis Marion Manor.	nt to the
	racility residents. Ba	sed on the comprehensive		(continued	F 684)

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/16/2018 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	530A1 40A9C5A49TC5ACA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	
		495384	B. WING_		04/26/2018
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#### F 684 Continued From page 17

assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to provide services to meet the highest practicable level of well-being for 2 of 21 residents in the survey sample (Resident #29 and #22).

The findings included:

1. The facility staff failed to use non-pharmacological interventions prior to the administration of a pain medication for Resident #29.

Resident #29 was admitted to the facility on 5/26/17 with the following diagnoses of, but not limited to high blood pressure, hip fracture, anxiety disorder, depression and Chronic Obstructive Pulmonary Disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/24/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #29 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

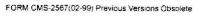
The surveyor performed a clinical record review of Resident #29 on 4/25 and 4/26/18. During this review, the surveyor noted that the resident had a physician order for the following medication:

#### F 684 Continued F 684

- 1. #29 received pain medication without non-pharmacological approaches documented; however, resident frequently requests team members to come to her room for various reasons. Team members have been educated to document those trips in and out of her room to demonstrate the non-pharm approaches that are made throughout the day. #22 recieved no ill effects from the blood sugar not being rechecked at 1:20 am on 12/25/17. The nurse who did not follow the physician's order was re-educated and instructed to follow the orders received by the physician and to be sure those results are documented.
- 2. All residents have the potential to be affected by the same deficient practice.
- 3. Team members are being re-educated to always document non-pharmacological approaches to pain management prior to administering pain medication. Education also provided to always follow physicians orders and to document thoroughly those results.

Team members are also required to document follow up for residents experiencing abnormalities for an extended period.

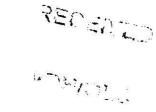
- 4. Audits will be done to check for non-pharm approaches to pain management and completion of physician orders. 20 audits weekly for eight weeks and then monthly for six months. Education will be provided to team members on the spot as needed. These results will be presented to QAPI for further direction.
- 5. Corrective action will be achieved by May 31, 2018



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Facility ID VA0086

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NAME OF PROVIDER ON SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION    X41D   X41D   (EACH PERTICIPATION PRIEFY   EACH OPEN PRIEFY   EACH PERTICIPATION PRIEFY   EACH PERTICIPATION PRIEFY   EACH PERTICIPATION   EA						
FRANCIS MARION MANOR HEALTH & REHABILITATION  INATIO FRANCIS MARION LARE, PO BOX 880 MARION, VA 24354  INATIO FRETIX (EACH DEFICIENCY MUST BE REFECEDED BY PILL REPORT OF CORRECTION SHOULD BE COMPETED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684 Continued From page 18  "Cyclobearzaprine 10 mg (milligram) Give 0.5 tablet by mouth every 12 hours as needed for leg pain". The surveyor also reviewed the MAR (Medication Administration Record for Resident #25 for the month of April 2018. This pain medication was administrated to the resident on the following dates and times: 4/3/18 at 2000 (8 pm), 4/4/18 at 10.34, 4/6/18 at 12.45 (9/45 pm), 4/7/18 at 21.20 (9/22 pm), 4/2/18 at 20.20 (8 20 pm), 4/2/18 at 20.00 (8 pm), 4/2/18 at 20.00 (8 pm), 4/2/18 at 20.00 (8 pm), 4/2/18 at 21.00 (9/20 pm), 4/2/18 at 2/20 pm), 4/2/18 at 2/20 pm, 4/2/18 at 2/20 pm, 4/2/18 at 2/20 pm, 4/2/18 at 2/20 pm, 4/2/2/18 at 2/20 pm, 4/2/2/18 at 2/20 pm, 4/2/2/18 at 2/20 pm, 4/2/2/18 at 2/20 pm, 4/2/2/			495384	B. WING		04/26/2018
FRANCIS MARION MANOR HEALTH & REHABILITATION  MARION, VA 24354  MARION, VA 24354  MARION, VA 24354  MARION, VA 24354  F 684  F 684  Continued From page 18  "Cyclobenzaprine 10 mg (milligram) Give 0.5 tablet by mouth every 12 hours as needed for leg pain." The surveyor also reviewed the MAR (Medication Administration of her billowing dates and times: 4/3/18 at 2000; 8 pm), 4/4/18 at 19.2018. This pain medication was administrated to the resident on the following dates and times: 4/3/18 at 2000; 8 pm), 4/4/18 at 19.200; 8 pm), 4/4/18 at 19.200; 8 pm), 4/16/18 at 20.00; 8 pm), 4/17/18 at 20.20; 8 20 pm), 4/20/18 at 19.25; 7 25 pm), 4/12/18 at 20.00; 8 pm), 4/17/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 19.25; 7 25 pm), 4/21/18 at 20.00; 8 pm), 4/20/18 at 20.00; 8 pm), 4/20/18 at 20.00; 8 pm), 4/20/18 at 20.00; 9 pm, 4/20/18 at 20.00; 9 pm), 4/20/18 at	NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION THE APPROPRIATE COMMENTARY OF THE APPROPRIATE COMMENTARY OF THE MOUNT OF THE APPROPRIATE COMMENTARY OF THE APPROPRIATE COMM	FRANCIS	MARION MANOR HEALT	H & REHABILITATION		2010/00/00 NA 10 21 10 8150	ř
"Cyclobenzaprine 10 mg (milligram) Give 0.5 tablet by mouth every 12 hours as needed for leg pain". The surveyor also reviewed the MAR (Medication Administration Record for Resident #29 for the month of April 2018. This pain medication was administrated to the resident on the following dates and times: 4/3/18 at 2000 (8 pm), 4/4/18 at 10:34, 4/6/18 at 121:45 (9.45 pm), 4/7/18 at 20:20 (9.20 pm), 4/6/18 at 121:45 (9.45 pm), 4/17/18 at 20:00 (8 am) and 21:33 (9:38 pm), 4/16/18 at 20:00 (8 am) and 21:33 (9:38 pm), 4/16/18 at 20:00 (8 pm), 4/17/18 at 20:20 (8 20 pm), 4/20/18 at 19:25 (7:25 pm), 4/21/18 at 20:40 (8:40 pm), 4/22/18 at 21:03 (9:03 pm) and 4/25/18 at 23:45 (11:45 pm). The surveyor reviewed the nurses' notes for the above documented dates and times and there was no documentation of non-pharmacological interventions provided to the resident prior to the administration of the above stated pain medication.  The surveyor notified the administrative team on 4/26/18 at 4:04 pm in the conference room.  No further information was provided to the surveyor prior to the exit conference on 4/26/18.  2. The facility staff failed to follow the physician order to obtain a blood sugar for Resident #22' sclinical record on 4/24/18 through 4/26/18. Resident #22 was admitted to the facility 4/11/15 with diagnoses that included but not limited to diabetes mellitus type 2, status post pneumonia,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	HOULD BE COMPLETION
hemorrhage, status post respiratory failure, deconditioning, polysubstance abuse.	F 684	"Cyclobenzaprine 10 tablet by mouth every pain". The surveyor a (Medication Administr #29 for the month of Amedication was administred following dates and pm). 4/4/18 at 10:34, 4/7/18 at 21:20 (9:20 pm). 4/12/18 at 20:00 (8 pm). 4/20/18 at 19:25 (8:40 pm). 4/22/18 at 4/25/18 at 23:45 (11:4 reviewed the nurses' documented dates and documentation of nor interventions provided administration of the amedication.  The surveyor notified 4/26/18 at 4:04 pm in No further information surveyor prior to the example of the surveyor prior to the example of the surveyor reviewer record on 4/24/18 throws admitted to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the fidiagnoses that included diabetes mellitus type seizures, febrile epischemorrhage, status per surveyor prior to the survey	mg (milligram) Give 0.5 12 hours as needed for leg also reviewed the MAR ation Record for Resident April 2018. This pain instrated to the resident on ind times: 4/3/18 at 2000 (8 4/6/18 at 21:45 (9:45 pm), pm), 4/8/18 at 19:30 (7:30 (6 am) and 21:38 (9:38 pm), m), 4/17/18 at 20:20 (8:20 17:25 pm), 4/21/18 at 20:40 21:03 (9:03 pm) and 5 pm). The surveyor notes for the above and times and there was no in-pharmacological did to the resident prior to the above stated pain  the administrative team on the conference on 4/26/18. It was provided to the exit conference on 4/26/18.	, F 68	4	

If continuation sheet Page 19 of 46



hypertension, coronary artery disease. esophageal reflux, hyperlipidemia, peripheral

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAID SERVICES

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CENTER	S FUR WEDICARE &	WEDICAID SERVICES		<u> </u>	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B WNG_		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER		Section (Control of Control of Co	STREET ADDRESS, CITY, STATE, ZIP CODE	
FDANCIS	MADION MANOD HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880	
TRAITOIS	MARION MANOR HEAD	THE REPABLICATION		MARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 684	Continued From pag	ne 19	F 68	4	
		estroesophageal reflux	1 00	7	
		order, tobacco abuse, and			
	with an assessment	ral minimum data set (MDS) reference date (ARD) of			
		e resident with a BIMS (brief status) as 15 out of 15.			
	555	ted 12/24/17 23:20 (11:20			ļ
		nty of water to drink & ugar) in 2 hours & notify MD			
		S remains 400 & more."			
		d sugar on 12/24/17 at 9:00			
	p.m. was 483.				
	The surveyor review	ed the December 2017			
		n administration record but			
		the results of the rechecked			
	The state of the s	rveyor reviewed the 12/24/17 ogress notes. There were no			
		ne progress note dated			
		1:20 p.m.) that repeated the			
	physician order of 12			8	
	The surveyor inform	ed the administrator and the			
	director of nursing ([	OON) on 4/26/18 at 11:42			
		ewed the clinical record but			
		the results of the blood			
	<u></u>	ve been repeated after 9:00 he surveyor asked for the			
		abetic management. The			
		ity did not have a policy on			
	No further information	on was provided prior to the //26/18.			
F 756		ew, Report Irregular, Act On	F 75	6	

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

Event ID: ILEG11

Facility D VA0086

If continuation sheet Page 20 of 46





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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL <sup>*</sup> A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING		04/26/2018	2
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY STATE, ZIP CO		
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BO MARION, VA 24354	( 880	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLE TE APPROPRIATE DATE	TION
	must be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's med §483.45(c)(4) The phirregularities to the at facility's medical direct and these reports mu (i) Irregularities includrug that meets the condition of this section for (ii) Any irregularities reduring this review museparate, written report attending physician a director and director and director and the irregularity the (iii) The attending phyresident's medical rectirregularity has been action has been taken be no change in the resident of	imen Review.  ug regimen of each resident least once a month by a view must include a review ical chart.  armacist must report any tending physician and the ctor and director of nursing. Is to be acted upon. Ide, but are not limited to, any riteria set forth in paragraph an unnecessary drug, noted by the pharmacist st be documented on a port that is sent to the not the facility's medical of nursing and lists, at a a tr's name, the relevant drug, is pharmacist identified. It is sent to the cord that the identified reviewed and what, if any, in to address it. If there is to nedication, the attending ument his or her rationale in	F	Drug Regimen Review and for important to the team at France 1. Resident #59 received no important to the team at France 1. Resident #59 received no important to the team at France 1. Resident #59 received no important to the need for this med #69 did not have a diagnosis frantipsychotic. The physician valuagnosis. The pharmacy was need to flag the need for diagnosis. The pharmacy was need to flag the need for diagnosis to flag the need for diagnosis. The pharmacy was need to flag the need for diagnosis. An audit or review all residents with print to ensure there is a stop date of there is a diagnosis to support medication.  3. Implementing the new weel for monitoring use of the antipping medications will address the similar each medication has support the use of the medicat will be provided to team meber to the pharmacist of the required.  4. An audit to validate complete assessment will be conducted weeks and then monthly for simplements and will provide re-educted weeks and will provide re-educted results of the audit will be pre-	cis Marion Manor  I effects from the The physician has dication. Resident for the use of the will address the notified of the losis and behaviors  tial to be affected dit was conducted psychotropic medsentered and that the use of the losis and behaviors of the losis and behaviors with the use of the losis and the losis and losis a diagnosis to losis. Education is, physicians and lements.	
	§483.45(c)(5) The fac maintain policies and drug regimen review t limited to, time frames	cility must develop and procedures for the monthly that include, but are not so for the different steps in the pharmacist must take		QAPI team for further recomm 5. Corrective action will be co May 31, 2018.	endations.	

when he or she identifies an irregularity that

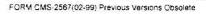
PRINTED: 05/16/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 495384 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 756 Continued From page 21 F 756 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical document review the pharmacist failed to notify the facility staff that a Resident's as needed antipsychotic was limited to 14 days and required physician review and failed to ensure that behavior monitoring was being done for 2 of 21, #59 and #69. 1. For Resident #59, facility staff failed to ensure that a PRN (as needed) order for an antipsychotic medication was limited to 14 days and administered a PRN antipsychotic medication after 14 days without a physician examining the resident and renewing the order. Resident # 59 was admitted to the facility on 3/19/18 with diagnoses including anemia, coronary artery disease, hypertension, peripheral vascular disease, gastroesophageal reflux disease, neurogenic bladder, Alzheimer's disease, anxiety disorder, and nontraumatic cerebral hemorrhage. On the admission minimum data set assessment with assessment date 3/28/18, the resident scored 3/15 on the Brief Interview for Mental Status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others. Clinical record review on 4/26/18 revealed an order dated 3/19/18 for Haloperidol 2mg/ml 0.5ml by mouth sublingually every 6 hours as needed for agitation. The medication administration record documented administration

on 4/24/18 at 23:18. The medical record did not document a physician review and renewal of the antipsychotic medication order after 14 days. The

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			2000	OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
3		495384	B. WING_			04/26/2018
NAME OF PI	ROVIDER ÖR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE	
EDANCIS	MARION MANOR HEAL	TU 9 DEUADII ITATIONI		100 FRANCIS MARIO	N LANE, PO BOX 880	
FRAITOIS		THE REPARE LITERATION		MARION, VA 24354	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)	
F 756	Continued From page	22	F7	· ·56		420%
		eview indicated that a review				
		18 was marked "see report				
	for any noted irregula					
		The surveyor was unable to				
		commendation in the record.				
	The surveyor reporter	the concern to the				
	TO THE PROPERTY OF THE PROPERTY OF THE PARTY	ector of nursing (DON)				
		eeting on 4/25/18. On				
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	orted that the nurse had not				
		e administration of the				
	haloperidol. There w	as no record of a physician				
	reviewing and renewi	ng the order.				
		pharmacy staff failed to				
		a diagnosis for the use of the				ĺ
		he antipsychotic medication				
	was ordered.	To diffey diffetion medication				
	04/26/18 11:51 AM	Resident # 69 received				
	quetiapine 50 mg at b					
	unspecified dementia					
		as no record of behaviors				
	150	chotic medication or of				
	behavior monitoring of	1 No. of the Control				
	antipsychotic medicat	юп,				
	Resident #69 was add	mitted to the facility on				
	10/6/17 with diagnose					
		ta set assessment with				
		18, the resident scored 3/15				
		for mental status and was				
		signs of delirium, or behavior				
	3 <del>7</del> 7	resident was assessed with				
	wandering 1-3 of the	prior ruays.				



During clinical record review on 4/26/18, the



Facility ID VA0086

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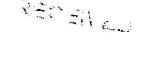
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	197,4144		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Maria Charles Arreston	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495384	B. WING_		04/26/2018
	ROVIDER OR SUPPLIER	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 100 FRANCIS MARION LANE, PO BOX MARION, VA 24354	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET ON BE APPROPRIATE DATE
F 756	quetiapine 50 mg give bedtime for unspecifie Diagnosis Report liste Unspecified Dementia Disturbance.  The resident's Medica and Treatment Admin document monitoring resident was being tremedication.  The surveyor asked to symptoms the antipsy intended to treat. The symptoms.  The pharmacist review 2/8/18, 3/15/18, and 4 concern that there was for the use of an antip symptoms were documental to the symptoms.	sician order 1/15/18 for a 1 tablet by mouth at a ded dementia. The resident's ad Principal Diagnosis as a without Behavioral ation Administration Record istration Record did not of behaviors for which the eated with antipsychotic are resident's nurse which rehotic medication was a nurse was unable to name wed the resident's orders on 1/12/18 and did not report a se no diagnosis appropriate asychotic medication, no mented as being treated by dication, and there was no nitoring to assess the eatment with an	F7	'56	
	notified of the concert on 4/26/18. Drug Regimen is Free CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug		F 7	57 F757 Providing a drug regimen free drugs to Residents is a priority Francis Marion Manor Health	y for the team at

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CENTER	C EOD MEDICADE O	MEDICALD SERVICES			FORM APPROVED		
		MEDICAID SERVICES			OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A, BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495384	B. WING	<u> </u>	04/26/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0412010		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880 MARION, 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 757	Continued From page	24	F 75	7 Continued F 757			
	§483.45(d)(1) In exceduplicate drug therapy	у); ог		<ol> <li>Resident #290 received no ill effects the missing the blood pressure and pulse pringing the medications from 4/21/18 through the medications from 4/23/18. The MAR was corrected on 4/2</li> </ol>	ior to ugh		
	§483.45(d)(2) For exc	essive duration; or		alert the team to check the blood pressur and pulse prior to administering med. Te	re		
	§483.45(d)(3) Without	t adequate monitoring; or		members were educated on how to enter the alert. Resident #22 received no ill effects from pat receiving his aliding copie as addered. Team			
	§483.45(d)(4) Without use; or	t adequate indications for its	not receiving his sliding scale as ordered. Team members involved were re-educated to follow the sliding scale on insulins.				
	§483.45(d)(5) In the p consequences which i reduced or discontinue	indicate the dose should be	2. All residents have the same potential to be affected by the deficient practice. Resident records were reviewed to identify others who have orders with parameters to ensure the MAR is set up correctly and parameters are being documented. Additionally, records were audited to ensure insulin administration with parameters is also being administered as indicated.				
	stated in paragraphs ( section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced					
	by: Based on staff interview the facility staff	ew and clinical record f failed to ensure 2 of 21 of unnecessary medications.		<ol> <li>Nursing team members were re-educategrating adding alerts to the eMAR to a managing the need for follow-up for certain medications.</li> </ol>	issist in		
	The findings included:			<ol> <li>Audits will be conducted by the Shift L medications with special instructions. Th will be conducted 10 times weekly for four</li> </ol>	nese audits		
		the facility staff failed to re and pulse prior to the medications		and monthly for six months. When issue identified, an intervention will be implemented to QAPI for furt recommendations.	ented.		
		dmitted to the facility on included but not limited to		<ol><li>Corrective action will be completed by May 31, 2018</li></ol>	1		

04/21/18. Diagnoses included but not limited to weakness, fatigue, orthopnea, congestive heart failure, dyspnea, rapid atrial fibrillation, hypertension, gastroesophageal reflux disease.

pancytopenia, chronic kidney disease, hypomagnesemia, and severe malnutrition. There has not been an MDS completed, as





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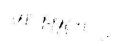
		MEDICALD SERVICES				FORM APPROVED
		MEDICAID SERVICES	The second second	and the second of the second o	<u> </u>	<u>IB NO. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI:	TIPLE CONSTRUCTION  NG	(X3	) DATE SURVEY COMPLETED
		495384	B. WING_		ł	04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	W 10 SPECIAL	S ALM 10-4	STREET ADDRESS, CITY, STAT	TE ZIP CODE	7,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE MARION, VA 24354	E, PO BOX 880	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page	e 25	F:	757	<i>3</i> .	
		mit, however Resident is	0, 10	υ·		
	04/25/18. It contained summary which read tablet 25 mg Give 25 for bp (blood pressure rate) < 50, or SBP (sy Notify MD if dose is h date of 04/21/18.  Resident #290's eMA record was reviewed which read in part, "M mg Give 25 mg by mc (blood pressure). Hold 50, or SBP (systolic b Resident's BP or puls having been done on	cal record was reviewed on a signed physician's order in part, "Metoprolol tartrate mg by mouth every 8 hours e). Hold med if HR (heart estolic blood pressure) < 90. eld". This order had a start  R (electronic medication and contained an entry letoprolol tartrate tablet 25 buth every 8 hours for bp d med if HR (heart rate) < lood pressure) < 90". The e had not been recorded as 04/21/18 at 10 pm, m, or 10 pm and 04/23/18 at				
	were discussed with t	issing BP and pulse rate's he administrative team I4/25/18 at approximately				
	regarding Resident #2 pulse and BP should recorded prior to the a medications.	at approximately 1100 290. DON stated that the have been taken and administration of the				
		was provided prior to exit.				



order for the administration of sliding scale insulin based on the blood sugar parameters for







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		NO HOWAIN SERVICES			FORM APPROVED
		MEDICAID SERVICES		36	OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. W.NG		04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	School Section 1	1000	STREET ADDRESS, CITY, STATE, ZIP COD	
FRANCIS MARION MANOR HEALTH & REHABILITATION			100 FRANCIS MARION LANE, PO BOX MARION, VA 24354	880	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
F 757	Continued From page Resident #22.	≥ 26	F 7	57	
	record on 4/24/18 throwas admitted to the fadiagnoses that include diabetes mellitus type seizures, febrile epischemorrhage, status prodeconditioning, polysi hypertension, coronar esophageal reflux, hy vascular disease, gast disease, bipolar disortibia fracture and obest disease, bipolar disortibia fracture and obest disease. Production of the fadiabetes of the interview for mental state of the fadiabetes with the following of the fadiabetes with the fadiabetes with the fadiabetes with the fadiabetes with the fadiabetes of the f	ed but not limited to 2, status post pneumonia, ode, subarachnoid ost respiratory failure, ubstance abuse, ry artery disease, perlipidemia, peripheral stroesophageal reflux der, tobacco abuse, right sity.  Il minimum data set (MDS) eference date (ARD) of resident with a BIMS (brief tatus) as 15 out of 15.  We care plan initiated in 5/19/17 identified a d "Resident #22 has ne status r/t (related to) rith complications, nedication as ordered by ument for side effects and FSBS (finger stick blood			
	Scale."  The April 2018 signed Resident #22 were real				

The physician orders read "Humalog 100 units/1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL/ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER) COMPLETED A. BUILDING 495384 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 757 Continued From page 27 F 757 ml (milliliter) vl (vial) Inject as per sliding scale: If 0-69=0 units < (less than) 70, Give Dextrose 4, (<60. Give 2) wait 15-20 min (minutes), recheck BS (blood sugar), notify MD (medical doctor); 70-150=0 units 151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units 401 + =20 units Give 20 units, notify MD Subcutaneously before meals and at bedtime for diabetes." The surveyor reviewed the April 2018 electronic medication administration record and identified the following areas of concern: 4/4/18 11:00 a.m. The blood sugar was 265: however, there was no unit amount of insulindocumented that was administered. Based on the physician order, the resident should have received 12 units. The 4/4/18 progress note [written at 1800 (6:00 p.m.) ]did not acknowledge the amount of insulin administered at 11:00 a.m. 4/4/18 at 2100 (9:00 p.m.) Resident #22's blood sugar was 407 and 20 units of insulin was administered. However, based on the physician order, the physician should have been notified when the blood sugar was greater than 401. The surveyor found no documentation that the physician order to notify the MD if the blood sugar was greater than 401 was done. There was not a progress note on 4/4/18 at 9:00 p.m. or thereafter

4/7/18 5:00 p.m. Blood sugar was 403. The surveyor found no evidence the physician was notified of the elevated blood sugar greater than

on 4/4/18.

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

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OEITTE!	OT OR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ED A MOIO	Managara			100 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR HEA	LTH & REHABILITATION		MARION, VA 24354		
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- Mar.	· · · · · · · · · · · · · · · · · · ·			DEFICIENCY)	<del></del>	
F 757	Continued From pa	ge 28	F 75	7		
		o progress notes written	, , ,			
	4/7/18.	o progress notes written				
	4/7/18 at 9:00 p m	Blood sugar was 405. The				
		evidence the physician was				
		ted blood sugar greater than				
		progress notes written				
	4/7/18					
	4/17/18 5:00 n m B	lood sugar was 422. The				
		1 4/17/18 at 4:15 p.m. did not				
		22's elevated blood sugar or				
	physician notificatio	<del>-</del>				
	7 <u></u>					
		ned the administrator and the				
	S 1070	of the above issue during the				
	The state of the s	ting on 4/25/18 at 4:42 p.m.		E 750		
		sted the facility policy on nt. The DON stated the		F 758 The team at Francis Marion Manor Health	. Ž	
	<del></del>	a policy on diabetes.		Rehabilitation feels it is very important to		
	racinty did not have	a policy of diabetes.		Residents are free from any unnecessary		
	No further information	on was provided prior to the		of psychotropic medications including prn		
	exit conference on			4 <b>-</b> 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		
F 758	Free from Unnec Ps	sychotropic Meds/PRN Use	F 758	<ol> <li>Education provided to team members to document behaviors and sign/symptoms of</li> </ol>	of the	
	CFR(s): 483.45(c)(3	1		meds and		
	§483.45(e) Psychot	ropic Drugs		#10. Further, re-education was provided to	to the	
		chotropic drug is any drug that		nurse caring for resident #59. When ente		
		es associated with mental		order into PCC, nurse should include a sto	99. <b>9</b> 04 - 80. 6 7 9 9 9 9 9 9	
	processes and beha	avior. These drugs include,		which will appear on the eMAR. Then if the medication is needed beyond the stop date		
	but are not limited to	o, drugs in the following		nurse will notify the physician of the		
	categories:			need to visit the resident to determine the		
	(i) Anti-psychotic;			for a new order/prescription to either exter		
	(ii) Anti-depressant;			14 day use or to schedule the medication.		
	(iii) Anti-anxiety; and	d		physician will need to write a progress not explain his/her reasoning for the prescript		
	(iv) Hypnotic			continuance.		
	Based on a compre	hensive assessment of a				
	Annual Material States (1997)	A THE STATE OF THE		F758 contin	nued	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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		495384	B WING_	**************************************	04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP CODE	100
FRANCIS	MARION MANOR HEALT	FH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 758	Continued From page	<b>2</b> 9	F 7	58 continued F 758	
	superior session of the clinical record;  \$483.45(e)(1) Reside psychotropic drugs are unless the medication specific condition as on the clinical record;  \$483.45(e)(2) Reside drugs receive gradual behavioral intervention contraindicated, in an drugs:  \$483.45(e)(3) Reside psychotropic drugs purpless that medication diagnosed specific coin the clinical record;  \$483.45(e)(4) PRN or are limited to 14 days \$483.45(e)(5), if the appropriate for the Proposition of the properties of the appropriateness of the properties of the proper	nts who have not used to not given these drugs in is necessary to treat a diagnosed and documented. It was a client of the property of the pro		2. All residents receiving psychotropic the same potential to be affected by thi An audit is being conducted to determi diagnoses, to ensure medication is trul to ensure behaviors are being monitore PRN meds are limited to no more than  3. Implementing the new assessment address diagnoses, dradual dose redubehavioral interventions, PRN limitation demonstrate the ongoing need for the rifthat is the case. This process began 2018.  4. The Assistant Nurse Managers will validate completion of the assessment four weeks and then monthly for six me each resident receiving a psychotropic Results of the audit will be presented to QAPI team for further recommendation  5. Corrective action will be completed May 31, 2018.	s practice. ne need for y needed. ed and that 14 days.  will ctions, ns and medication May 21.  audit to weekly for medication. o the s.

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

Based on staff interview and clinical record review, the facility staff failed to ensure 7 of 21 residents were free of unnecessary psychotropic

Event ID: ILEG11

Facility D VA0086

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		ID HUMAN SERVICES				FORM APPROVED
CENTER	<u>S FOR MEDICARE &amp; I</u>	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP (	CODE	O-FIZOIZO ID
FRANCIS	MARION MANOR HEALT	TH & REHARII ITATION	\$	100 FRANCIS MARION LANE, PO B	OX 880	
FRANCIS MARION MANOR HEALTH & REHABILITATION			MARION, VA 24354			
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F 750		35%	38.	24 10 10 10 10 10 10 10 10 10 10 10 10 10		
F /58	Continued From page	∍ 30	F7	58		
	medications (Residen	t #26, Resident #12.				
	Resident #40, Reside					
	Resident #69 and Res	sident #10).				
	The findings included	y N				
	was free of unnecess, medications. The fact the use of psychotrop mg (milligrams) bid (to daily, and Quetiapine Resident #26's clinica 4/24/18 through 4/26/admitted to the facility 12/16/17 with diagnost limited to cerebral her dementia, diabetes m depression, hyperlipic	ility staff failed to monitor ic medications-Klonopin 0.5 wice a day), Paxil 40 mg 25 mg at bedtime.  Il record was reviewed 18. Resident #26 was 8/21/17 and readmitted ses that included but not morrhage, insomnia, ellitus type 2, hypertension.				
	gastroesophageal refl					
	(MDS) assessment w reference date (ARD) resident with a BIMS status) of 2 out of 15. resident with altered le with behaviors that in that did not affect other	erly minimum data set ith an assessment of 2/23/18 assessed the (brief interview for mental The facility assessed the evel of consciousness and cluded verbal, physical and ers. The facility staff did not with any signs or symptoms				
		ve care plan initiated s area that read Resident c medications r/t (relate to)				





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behavior management from anxiety, agitation, risk of depression, disease process of cognitive

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING\_ 495384 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 31 F 758 impairment and pain of head ache to right shoulder in addition to threatens potential for injury to others. Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. Observe record occurrence of for target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility policy. The care plan did not address any specific targeted behaviors or interventions to use for Resident #26's when targeted behaviors were observed. The surveyor reviewed the signed April 2018 physician order sheet (POS). Resident #26 had orders for Klonopin 0.5 mg by mouth two times a day for agitation, Paroxetine 40 mg daily for depression, and Quetiapine Furnarate 25 mg 0.5 mg at bedtime for dementia with behavioral disturbances. The surveyor reviewed the April 2018 electronic medication administration records (eMAR) and found no evidence of behavior monitoring on the eMAR or monitoring of the effects/side effects of each of the psychotropic medications. During the end of the day meeting on 4/25/18 at 4:42 p.m., the surveyor asked the administrator and the director of nursing (DON) where the staff document Resident #26's behavior and the justification for the use of Klonopin, Paroxetine. and Quetiapine. The DON stated, "We rely on

nurse's notes and the documentation in those notes. The staff only document if there are issues or behaviors going on and those would be

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING		04/26/2018
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CO 100 FRANCIS MARION LANE, PO BO MARION, VA 24354	ODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 758	Continued From pa	ge 32	F 75	8	
	notes. The 4/11/18 patient kicked at ce	wed the April 2018 progress progress note stated that rtified nursing assistant when o do ADL (activities of daily			
	"Resident #26 was times. She was cur and was told to shu	rogress note read in part yelling out like she does at rsed loudly by another resident t up. According to RN his patient screamed back at			
	has increased anxie bed and yelling out to a Geri chair so sh desk to be with the	rogress note read "Pt (patient) ety. Pt kept trying to get out of for her son. Pt transferred x2 ne could come up to the front nursing staff. 0320 Sleeping ably with blanket over her."			
	and scratched certif they were transferrin Resident #26 grabb pull it off one of the the resident's hands	.m. progress note read "Pt hit fied nursing assistants while ng patient from Geri chair. ed the lanyard and tried to aides. The nurse had hold of and calmly told the resident e going to do and she calmed des change her."			
	on 4/26/18 at 11:23	the director of nursing (DON) a.m. if the facility had policies otropic medications. The cy.			
	No further information	on was provided prior to the 4/26/18.			

2. The facility staff failed to ensure Resident #12

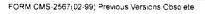
PRINTED: 05/16/2018

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 495384 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 33 F 758 was free of unnecessary psychotropic medications. The facility staff failed to monitor the use of Citalopram 20 mg (milligram) at bedtime, Lorazepam 0.5 mg twice a day for anxiety, and Risperidone 0.25 mg at bedtime. The clinical record of Resident #12 was reviewed 4/24/18 through 4/26/18. Resident #12 was admitted to the facility 5/2/15 with diagnoses that included but not limited to hypertension, heart failure, osteoarthritis, gait abnormalities, anemia, major depressive disorder, unspecified psychosis, dementia without behavioral disturbances, anxiety disorder, rheumatoid arthritis, constipation, and hemiplegia/hemiparesis following cerebrovascular disease affecting unspecified side. Resident #12's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/5/18 assessed the resident with a BIMS of 9 out of 15. Resident #12 had no signs of delirium or behaviors but was assessed to have delusions. Resident #12's current comprehensive care plan was reviewed. A focus area for behaviors was initiated 4/3/17 and read "Resident has a behavior problem of yelling from room for assistance most often when alone, increase confusion, severe dementia with delusions and hallucinations. Nursing staff reports the resident has behaviors of calling staff names and yelling out often while awake. Interventions: Administer medications as ordered by MD (medical doctor). See MAR (medication administration record).

Observe/document for side effects and effectiveness. Focus area for dementia was identified on 11/22/16. Interventions: When she

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING \_ 495384 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLET ON DATE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 34 F 758 is agitated, attempt to redirect before transferring. Focus area for psychotropic drug use identified 11/22/16. Interventions: Administer medications as ordered by physician. Observe/document/report any adverse reactions: change in behavior/mood/cognition; hallucinations/delusions; social isolation. Focus area of mood problem identified 2/13/17. Resident #12 yells out at staff and residents if they are outside her room. She thinks the facility is her house. Interventions: Try to determine the cause of the behavior. The surveyor reviewed the April 2018 physician order sheet. Resident #12 had orders for Citalopram 20 mg at bedtime for psychosis. Lorazepam 0.5 mg twice a day for anxiety, and Risperidone 0.25 mg at bedtime for psychosis. The surveyor reviewed the April 2018 electronic medication administration record (eMAR). The April 2018 eMAR did not have documented monitoring of the effects/side effects of the psychotropic medications (Citalogram. Lorazepam and Risperidone) or any targeted behaviors identified. During the end of the day meeting on 4/25/18 at 4:42 p.m., the surveyor asked the administrator and the director of nursing (DON) where the staff document Resident #12's behavior and the justification for the use of Citalopram, Lorazepam, and Risperidone. The DON stated, "We rely on nurse's notes and the documentation in those notes. The staff only document if there are



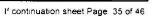
documented."

issues or behaviors going on and those would be

The surveyor reviewed the April 2018 progress



Facility ID VACOB6





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		495384	B. WING		<u> </u>	04/26/2018	
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FRANCIS MARION MANOR HEALTH & REHABILITATION			100 FF	RANCIS MARION LANE, PO BOX 880			
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F 758	Continued From pag	e 35	, F	: 758			
	(i)	o behavioral related notes	84.6	00			
		ent #12 did refuse a shower					
	on one occasion but bath instead.	accepted a complete bed					
	on 4/26/18 at 11:23 a	the director of nursing (DON) a.m. if the facility had policies tropic medications. The					
	No further informatio exit conference on 4, 3. The facility staff fa	n was provided prior to the		15 25 36			
	10/18/17 with the foll limited to heart failure diabetes, dementia, and Schizophrenia. (Minimum Data Set) Reference Date) of 3 coded as having a B Mental Status) score of 15. Resident #40 extensive assistance dressing and person	Imitted to the facility on owing diagnoses of, but not e, high blood pressure, anxiety disorder, depression On the quarterly MDS with an ARD (Assessment 1/10/18, the resident was IMS (Brief Interview for of 11 out of a possible score was also coded as requiring of 2 staff member for al hygiene and being totally member for bathing.					
	The surveyor perform on Resident #40 on review, the surveyor being given Celexa cand Questiapine twice behavioral disturbant the nurses' notes and Administration Record	ned a clinical record review 4/25 and 4/26/18. During this noted that the resident was daily for depression, Buspar, se a day for dementia with ces. The surveyor reviewed					

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING		04/26/2018
	ROVIDER OR SUPPLIER  MARION MANOR HEAL	TH & REHABILITATION	100	REET ADDRESS, CITY, STATE, ZIP CODE D FRANCIS MARION LANE, PO BOX 880 IRION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE A	ULD BE COMPLETION
F 758	Continued From page while receiving these		F 758		
	the above documented 4:04 pm in the confer asked the team if their documentation for Rebeen receiving the above The DON (director of have behavioral monito document any behavioral monitoral monito	the administrative team of ed findings on 4/26/18 at ence room. The surveyor re were any behavioral esident #40 while she has eve stated medications. nursing) stated, "We don't tor sheets. The nurses' are aviors in the nurses' notes."  In was provided to the exit conference on 4/26/18.  Iteled to monitor behaviors as receiving a psychotropic			
	9/6/17 with the follow limited to dementia w psychotic disorder with high blood pressure a quarterly MDS (Minim (Assessment References resident was coded a Interview for Mental Spossible score of 15. coded as requiring exmember for dressing being totally dependent bathing.  The surveyor perform of Resident #47 on 4/	admitted to the facility on ing diagnoses of, but not ith behavioral disturbances, the delusions, heart failure, and anxiety disorder. On the num Data Set) with an ARD one Date) of 3/16/18, the shaving a BIMS (Brief status) score of 00 out of a Resident #47 was also tensive assistance of 1 staff and personal hygiene and nt on 1 staff member for led a clinical record review 25 and 4/26/17. During this noted that the resident was			
		a day for anxiety and	No.		

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

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Facility ID VA0086

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495384	B. WING_		04/2 <del>6</del> /2018
NAME OF P	ROVIDER OR SUPPLIER	SARAN KOR		STREET ADDRESS, CITY, STATE, ZIP COD	
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 9 MARION, VA 24354	380
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	reviewed the nurses', Administration Recon 2018. There was no monitoring while the rethese medications.  The surveyor notified the above documented 4:04 pm in the confer asked the team if the documentation for Reference in the Book (director of have behavioral monito document any behavioral monitoral monitoral monitoral formation surveyor prior to the set of t	res. The surveyor also notes and MAR (Medication of) for the month of April documentation of behavioral resident has been receiving the administrative team of ad findings on 4/26/18 at ence room. The surveyor re were any behavioral resident #40 while she has rove stated medications, nursing) stated, "We don't tor sheets. The nurses' are aviors in the nurses' notes." In was provided to the exit conference on 4/26/18, accility staff failed ensure an arion was used to treat behaviors associated with a reatment by an antipsychotic sure monitoring of the he antipsychotic medication resident # 10's clinical record symptoms which the ion was to address. There wior monitoring of a resident	. F7	58	
	2/18/17 with diagnose	mitted to the facility on es including Parkinson's cts of anti-Parkinson drugs			

and other central muscle tone depressants, anemia, cognitive communication deficit, other

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CENTER	S FOR MEDICARE	& MEDIÇAID SERVICES		100		NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495384	B. WNG		:	04/26/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS CITY STATE, ZIP C		04/20/2010
FRANCIS	MARION MANOR HE	ALTH & REHABILITATION		FRANCIS MARION LANE, PO BO RION, VA 24354	)X 880	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 758	chronic kidney dis On the quarterly meth assessment of 14/15 on the brief was assessed as a psychosis, or behavior of the point of the point haloperidol decomilliliter ampoule intramuscularly in 17th and ending of the too their specified of the point he is used to the point of the surveyor was or in the clinical regregation.	ease, and major depression.  inimum data set assessment date 2/3/18, the resident scored interview for mental status and without signs of delirium. aviors affecting others.  ord review on 4/26/18, the ohysician order dated 1/24/18 canoate 100 milligram per 100 nject 0.75 milliliter the buttocks starting on the in the 17th every month related disorders of the brain.  ent on a pharmacy ort recommending a gradual DR) of the haloperidol declined hizophrenia worsens with GDR inable to stay in facility".  dication Administration Record ministration Record did not ing of symptoms or behaviors ent was being treated with ication.  unable to determine from staff cord what symptoms the without the antipsychotic	F 758			
		and director of nursing were cern during a summary meeting				

6. For Resident #59, facility staff failed to ensure

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<u>CENTER</u>	<u>IS FOR MEDICARE 8</u>	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495384	B WING		04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 8 MARION, VA 24354	80
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
F 758	Continued From pag	ne 39	F	758	
	medication was limit administered a PRN	antipsychotic medication taphysician examining the			
	3/19/18 with diagnost coronary artery diseavascular disease, gardisease, neurogenic disease, anxiety disease	dmitted to the facility on ses including anemia, ase, hypertension, peripheral stroesophageal reflux bladder. Alzheimer's order, and nontraumatic a. On the admission minimum with assessment date scored 3/15 on the Brief Status and was assessed as delirium, psychosis, or there.			
	order dated 3/19/18 0.5ml by mouth sublineeded for agitation, administration record on 4/24/18 at 23:18, document a physicia antipsychotic medical Medication regiment was conducted 4/12/for any noted irregular recommendations."	d documented administration The medical record did not n review and renewal of the tion order after 14 days. The review indicated that a review 18 was marked "see report			
ŧ	during a summary m 4/26/18, the DON rep	ed the concern to the ector of nursing (DON) eeting on 4/25/18. On corted that the nurse had not the administration of the			

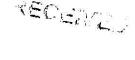
FORM CMS-2567(02-99) Previous Versions Obsolete

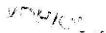
haloperidol. There was no record of a physician

Event ID: ILEG11

Facility ID VAC086

If continuation sheet Page 40 of 46





# DEPARTMENT OF HEALTH AND HUMAN OFFICE

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		ID HUMAN SERVICES  MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495384	B. WING		04/26/2018	
	ROVIDER OR SUPPLIER	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 8 MARION, VA 24354	80 90 80 NACOS	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 758	Continued From page reviewing and renewing		, F	758		
	antipsychotic medicat specific symptoms or diagnosis requiring tremedication and to ensymptoms for which the was ordered.  04/26/18 11:51 AM Figuetiapine 50 mg at bunspecified dementia disturbance. There we treated by the antipsy	behaviors associated with a satment by an antipsychotic sure monitoring of the ne antipsychotic medication  Resident # 69 received edtime for diagnosis without behavior as no record of behaviors chotic medication or of				
5	assessment date 4/6/ on the brief interview f assessed as without s	nitted to the facility on s including. On the ta set assessment with 18, the resident scored 3/15 for mental status and was ligns of delirium, or behavior resident was assessed with				
	surveyor noted a phys quetiapine 50 mg give bedtime for unspecifie	d dementia. The resident's d Principal Diagnosis as				

The resident's Medication Administration Record and Treatment Administration Record did not document monitoring of behaviors for which the

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE A BUILDING_	(X2) MULTIPLE CONSTRUCTION A BUILDING		
		495384	B. WING		04/26/2018
NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION		H & REHABILITATION	10	REET ADDRESS, CITY, STATE, ZIP CODE 10 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	0.75
F 758	medication. The surveyor asked t	e 41 eated with antipsychotic ne resident's nurse which echotic medication was	F 758		
	intended to treat. The symptoms.	e nurse was unable to name			
	2/8/18, 3/15/18, and 4 concern that there wa for the use of an antip symptoms were docu	eatment with an			
F 761		d director of nursing were n during a summary meeting d Biologicals	F 761		ì
SS=D	Drugs and biologicals	of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary			
	§483.45(h) Storage o	f Drugs and Biologicals			
	Federal laws, the faci biologicals in locked of	rdance with State and lity must store all drugs and compartments under proper and permit only authorized			

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CENTER	<b>₹S FOR MEDICARE &amp;</b>	MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495384	B. WING		04/26/2018	
NAME OF P	PROVIDER OR SUPPLIER		STREET /	ADDRESS, CITY, STATE, ZIP CODE	1 07/20/20/0	
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION	ALTERNATION OF THE PROPERTY OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	TADDRESS, CITY, STATE, ZIP CODE  ANCIS MARION LANE, PO BOX 880  DN, VA 24354  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  COMPLETION DATE		
F 761	personnel to have acceptable and date medicate discard expired expired expired expired medicate discard expired expired expired expired expired expired expired expired exp	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can  I is not met as evidenced on, staff interview and facility a facility staff failed to store ations when opened, failed adications and failed to ox permanently in 1 of 2	corre- Franc  1. Stc #62 v destre- re-ed has n All me been the m  2. All by the rooms prope  3. Ar condu- labele medic inspe-	eling and storing drugs and bio ectly is very important to the teacts Marion Manor Health & Restorage for insulin for residents a was corrected, including the oray date. Nursing team membraturated to this practice. The remow been secured in the medications from previous residence in the medications from previous residence in the part of the sent back to the pharmacy for medications can be properly distributed in the same deficient practice. All the same deficient practice. All the same deficient practice. In audit of all medication carts we fucted to ensure all insulins are led. The medication box is sectication room. Both medication from ected and all medications from	eam at chabilitation.  #76, #22 and open date and open dat	
	(a) The facility staff failed to date medications (insulins) when opened. The surveyor inspected the medication cart of licensed practical nurse #2 on 4/24/18 at 11:42 a.m.  The surveyor and L.P.N. #2 identified the following concerns with medications: An opened vial of Novolog U100 insulin dated 3/14/18 for Resident #76. An opened vial of Humalog U100 for Resident #22 that did not have a date when opened. An opened vial of Lantus U100 without a date when opened for Resident #62.		carts super then r found Resul QAPI 5. Co	will be conducted by the even rvisors 4 times weekly for four monthly for six months. Variand will be corrected at the time of all the first of the audit will be presented to the formula further recommendation or further will be completed.	ning shift weeks and nces of the audit ed to the ations	





L.P.N. #2 stated insulins were to be dated when opened but wasn't sure how long before Novolog

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BJILDING		(X3) DATE SURVEY COMPLETED
		495384	B. WING_		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FRANCIS	MARION MANOR HEAL	TH & DEHABILITATION		100 FRANCIS MARION LANE, PO BOX 8	80
TRAITOIC	MARION MARION HEAE	TO REPARE MATERIAL PROPERTY OF THE PROPERTY OF	27 2000 11 200	MARION, VA 24354	97
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 761	Continued From page	e 43	F	761	
	should be discarded				
	(b) The surveyor insp medication room on 4 licensed practical nur	l/24/18 at 11:50 a.m. with			
the counter that w L.P.N. #1 stated the box. Medications of were Oxycodone Soxycodone/APAP 10/325 mg, Morph Hyrodcodone /APA 10/325 mg, Xanax Klonopin 0.5 mg, 32.4 mg, and Zolp		ed a red toolbox sitting on not permanently affixed. colbox was the narcotics rently in the narcotic box g (milligrams), 325 mg, 7.5/325 mg, and (liquid and injectable), 5/325 mg, 7.5/325 mg, and 5 mg, Ativan 0.5 mg, modol 50 mg, Phenobarbital m 5 mg. Injectables g/2 ml (milliliter) and			
,	nurse from walking or with the narcotic box/ stated the narcotic bo from the medication of the nurse has to go the narcotic box has a loo from the pharmacy be pharmacy has to apprescription has to be	what prevented another ut of the medication room toolbox in hand. L.P.N. #1 ox could be easily removed from but to get into the box, frough the pharmacy. The first that you have to get a # afore it can be opened. The rove the staff opening it. A space before the pharmacy makes are to the pharmacy.			
	dose is in the box and correctly. Two nurses have to sign what lock	s have to sign together and ks you changed.			
	The surveyor and L.P medication cabinets in L.P.N. #1 stated medication.	the medication room.			

deceased residents, residents that had been

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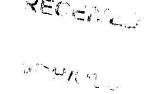
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ B. WNG 495384 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 761 Continued From page 44 F 761 discharged and medications that had expired. Thirty-three medications were identified as expired, the resident was deceased or the resident was no longer a resident of the facility. L.P.N. #1 stated she would notify the director of nursing and the pharmacy of the above concern. The surveyor informed the director of nursing (DON) of the above concern on 4/24/18 at 2:00 p.m. and the administrator of the above concern on 4/24/18 at 4:13 p.m. The surveyor requested the facility policy on opening, dating, storage and discarding medications on 4/24/18. The policy titled "Medication Management" was reviewed 4/25/18. VI, POLICY B 3, A. Insulin: i. Insulin injectables must be discarded after twenty-eight (28) days after initial entry with the exception of Levemir which is forty-two (42) days." The policy titled "8.1 Return Medications to the Pharmacy and Credits" was reviewed 4/25/18. "9. Facility should destroy medications that are not returnable to Pharmacy in accordance with Facility policy." The facility policy titled "Operations-Administration" was reviewed 4/25/18. The policy read in part "Il Purpose To outline the processes to securely store all medications and biologicals, including controlled (scheduled) medications, to prevent diversion and locked, when necessary, in accordance with all



applicable laws and regulations."

No further information was provided prior to the





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

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STATEMENT OF DEFICIENCIES  WARD PLAN OF CORRECTION  WAS BUILDING  495384  NAME OF PROVIDER OR SUMPLER  FRANCIS MARION MANOR HEALTH & REHABILITATION  NAME OF PROVIDER STATE JUP CODE  100 FRANCIS MARION LAME, PO BOX 880  MARION, V. A 2353  JOH D  SHAMMARY STATEMENT OF DEFICIENCIES  TAG  FEGULATION OR US OF DEFICIENCY  TAG  FREGIX  TAG  FOR CONTINUED FROM DEFICIENCY  TAG  FREGIX  FREGIX  TAG  FR	CENTER	FOR WEDICARE &	MEDICAID SERVICES			OWR NO. 0	<u>938-0391</u>	
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 761 Continued From page 45  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET ON DATE)  COMPLET ON DATE  F 761 Continued From page 45	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Page 200 Strategy 200 No. 200		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 761  Continued From page 45  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  ID  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE COMPLET ON DATE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  F 761			495384	B. WING		04/26/	2018	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 761 Continued From page 45  MARION, VA 24354  ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET ON DATE)  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF PR	OVIDER OR SUPPLIER	* ***		STREET ADDRESS, CITY, STATE, ZIP CODE			
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	PREFIX	(EACH DEFICIENC	ACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF		HOULD BE COMPLETION	
	F 761	Continued From page	s 45	E 70	, :1			
				F	) I			
		exit conference on 4/.	20/10.					
	9.8							

