PRINTED 06/19/2018 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OND NO. 0000-0001
10.5	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
		105112	B WING	C
VINE OF D	DOWNER OF CHROLIES	495143	STREET ADDRESS, CITY, STATE.	7P.CODE
NAME OF P	ROVIDER OR SUPPLIER		1607 SPRUCE STREET	ZII CODE
MARTINS	VILLE HEALTH AND REI	HAB	MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y WUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVI TAG CROSS-REFERENCE)	N OF CORRECTION (XS) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
E 000	survey, Complaint Su Preparedness survey through 06/04/18. Si required for complian Requirement for Long complaints were inve The census in this 13 117 at the time of the consisted of 42 curre	was conducted 05/29/18 gnificant Corrections are ce with 42 CFR Part 483.73, g-Term Care Facilities. Four stigated during the survey. 8 certified bed facility was survey. The survey sample nt Resident reviews and 3	E 000 Disclaimer: This plan of correction is compliance with specific requirements and the star plan of correction are not do not constitute an agree deficiencies herein. To with all federal and state facility has taken or is plactions set forth in the ficorrection. The following constitutes the facility's compliance. All alleged	c regulatory attements made on this of an admission to and ement with the alleged remain in compliance e regulations, the lanning to take the ollowing plan of ng plan of correction allegation of
F 000	closed record reviews		been or are to be correct F 000 indicated.	
	survey, Complaint Su Preparedness survey through 06/04/18. Sig- required for complian Requirement for Long	dicare/Medicaid standard rvey and Emergency was conducted 05/29/18 gnificant Corrections are ce with 42 CFR Part 483.73, p-Term Care Facilities. Four stigated during the survey.		
	117 at the time of the	cise of Rights	F 550	
	self-determination, an access to persons and	ht to a dignified existence, d communication with and	***	CEIVED
	§483.10(a)(1) A facilit	v must treat each resident	VĮ	DH/OLG

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

Administrator

TITLE

(XS) DATE

11/18/12018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whother 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 &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF B	ROVIDER OR SUPPLIER	400.42		STREET ADDRESS, CITY, STATE, 7IP CODE	00/04/2010
NAME OF PR	ROVIDER OR SUFFLIER			1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND REI	HAB	4.	MARTINSVILLE, VA 24112	
				2 <u>u</u> 100	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 550	Continued From page		F 5	50	
	with respect and digr	and in an environment that			
		ce or enhancement of his or			
	The production of the presentation of the party of the product of the production of	ognizing each resident's			
	individuality. The faci				
	promote the rights of				
	§483.10(a)(2) The fa	cility must provide equal			
		e regardless of diagnosis,			
	The same of the sa	or payment source. A facility			
		naintain identical policies and			
	and the second state of th	ransfer, discharge, and the under the State plan for all			
	residents regardless				
	§483.10(b) Exercise				
		right to exercise his or her			
		f the facility and as a citizen			
	or resident of the Uni	ted States.			
		cility must ensure that the			
		his or her rights without			
	from the facility.	n, discrimination, or reprisal			
	§483.10(b)(2) The re-	sident has the right to be			
	free of interference, of	coercion, discrimination, and			
		ity in exercising his or her			
		orted by the facility in the			
	exercise of his or her subpart.	rights as required under this			
	This REQUIREMENT	is not met as evidenced		RECE	EIVED
	by:	n recident and et-ff			
	Based on observation interview and clinical			- 日	114
		y staff failed to respect the			500
		dents while providing care		HOV	/OLC

(Residents #77, 86, 5 and 26).

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CENTERS	FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT PI A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING	1 6 9	C 06/04/2018
NAME OF PRO	OVIDER OR SUPPLIER		_1	STREET ADDRESS CITY, STATE, ZIP CODE	1 00/04/2018
				1607 SPRUCE STREET	
MARTINSV	LLE HEALTH AND RE	HAB		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
	the dignity of Resider The resident's clinica in the resident's clinica in the resident's clinica in the resident #77 was an in t	as #VI & II) failed to respect ent #77 while providing care. all record was reviewed on agnoses included ia, peripheral vascular ascular dementia, anxiety, obstructive pulmonary loss. Inimum data set) assessment ed the resident with nication ability, and intact e was coded as not having memory. ed the resident as feeling hopeless, feeling tired and reself. The resident was naving any issues with	F 55	21. CNA VI, CNA II. CNA I, CNA IV LPN I, received disciplinary action re failure to provide the dignity of reside and #26. Social Services Director fol residents #77, #86. #5 and #26 to eval any psychosocial distress. Social Services Director follow up with residents as needed. Resident #86 CCP updated to reflect it of supportive listening and providing Resident #26 notified in regards to recroommate. Staff member identified a disciplinary action due to failure to president #26. 2. Residents that reside in the facility potential to be effected by this deficie 3. Group re-education by Director Of Human Resources in regards to custor completed on 6/12/2018 and 6/13/201 required to complete Relias Training Resident's Rights, Customer Service, Service Essentials. Ombudsman to restaff regarding respecting the dignity facility. Patient Interview & Observa (Dignity/Resident Rights) Audit to be Social Service Director or Designe 5 x 8 weeks to ensure facility staff respector residents in the facility. 4. Results of audits will be brought to quarterly Quality Assurance Performal Improvement (QAPI) Meeting for revrecommendations implemented as independent of the provided as independent of the provi	garding F550 ent #77, #86, #5 lowed up with luate for vices to Intervention reassurance, reiving a new and received rec

documented a prescription for Depakote

Sprinkles 125 mg two times daily for behavior.

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CENTERS	S FOR MEDICARE 8	MEDICAID SERVICES	- (4)		OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIP	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER	\$ 050000	100000 10	STREET ADDRESS CITY, STATE, ZIP CODE	EA91
MARTINS	/ILLE HEALTH AND R	EHAB	į	1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIFS CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 550	A review of the MAF	y day was ordered on 9/2/16. R (medication administration I the medications were	F 55	0	
	dining room and sea When the food trays kitchen a staff mem wheelchair and whe	PM Resident #77 was in the ated at the table with peers. It is start coming out of the ber grabbed the resident's deled her back to south unit at a table with two CNAs are side.			
	out of the dining roo she eats second lur dining room and wa both started laughin	why the staff had moved her om and CNAs VI & II both said ach and just likes to sit in the tch everybody else eat. They g at this point and saying t she want to do that?"			
	wanted to eat her lu surveyor could reply CNA VI stated, "You	d at surveyor and said she ench in her room. Before the r, the CNAs laughed again u don't want to go to your tay out here with us."			
	her everytime she to dipped head looking and looked defeated resident again if she	ughing and talking over top of ried to respond. The resident g at the floor, pursed her lips d. The surveyor asked the e wanted to eat lunch in room up and said, "Tearfully, yesl om."			
	CNA VI stated, "I'll seat in your roombi	inued to chortle and laugh and see if your nurse will let you ut you're supposed to go to urveyor asked the staff			

members if the resident could feed herself. They

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

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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 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL /EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION; CROSS REFERENCED TO THE APPROPRIATE. TAG TAG DEFICIENCY F 550 Continued From page 4 F 550 said, yes. The surveyor then asked the CNAs why the resident needed the nurse's permission to eat in her room. They replied, "She don't." When second lunch came the resident was observed to be back in the dining room and left to eat there--unassisted. At 1:45 PM resident observed to be laying in bed. She was asked how it made her feel when we had the meeting at the unit table. She stated, "I didn't like it much--you could see I just got quiet and wouldn't speak to them anymore." Resident #77 said the CNAs hurt her feelings when they laughed at her. On 5/30/18 at 11:06 AM the facility resident council was interviewed about the staff's care and attitudes. Resident #124 spoke up and told the surveyor "Some of the CNAs are horrible to us....l think it's because they're short of help and they're irritable." Resident #33 stated, "The staff are nasty to us. We'll go to get a wash cloth from the linen cart because they won't bring us any. If they see you they holler at you, 'don't touch those rags' we need them!" The resident council members refused to give any names of the offending staff members. One resident #124 stated, "We've complained about them before. They never respond to anything we complain about. We feel like we're wasting our breath

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

On 6/3/18 at 7:45 PM LPN II was interviewed

Event ID: 56XM11

Facility ID: VA0159

If continuation sheet Page 5 of 126



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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	X3; DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> </u>	COMPLETED
					С
		495143	B. WING	total Mark 100	06/04/2018
NAME OF P	ROVIDER OR SUPPLIFE			STREET ADDRESS, CITY, STATE, ZIP CODE	ay — 402
MARTINS	VILLE HEALTH AND RE	HAB	ľ	1607 SPRUCE STREET	
000000000000000000000000000000000000000		estativité est		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (FACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 550	Continued From page	e 5	F 55	0	
	about the staff's attitu	ides towards resident. She			
	said she never had a	ny trouble with the residents			
		all how staff approached			
		ference. If they're not in the			
	time. "It's all how you	, I come back at another treat somehody "			
	amo. Rodannon you	mout demodedy.			
	LPN II said CNA I wa	s a "cold fish" and could			
		at times. She stated, "She			
	acts like everything is	s a chore."			
		M CNA VII told the surveyor			
	157	problems with some of the			
		some aides had problems			
		#5, & 86). If I go in and ust feave and come back			
	Description of the second of t	mind having care done.			
		a mood and want to be left			
	aloneI don't mind."				
	On 5/30/18 at 4:00 P	M the DON was informed of			
	the findings. She said	d if the resident wanted to			
	eat in her room, she	should be allowed to.			
	No additional information	ation was provided prior to			
	2. The facility failed t	o provide to respect the			
		86 while providing care.			
		dmitted to the facility on			
-0		on diagnoses included:			
		Complete amputation at knee			
	level, bilateral, and a	nemia.			
		MDS (minimum data set) he resident with unimpaired			

communications skills. His cognitive ability showed slight memory impairment during testing.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER:SUPPLIER:CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
	ROVIDER OR SUPPLIER	нав	160	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112	1 33/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DIBE COMPLETION
F 550	resident indicated the depressed or hopele and had little energy. The MDS captured the during the look back indicators for psychological, verbal or or documented. The representing staff care expecting staff care expecting to determine the mervention of at least ADLs (activities of discumented as able help only. The residuents and the staff care in the mervention of at least ADLs (activities of discumented as able help only. The residuents are staff to the mercent and the me	aesting indicated the e resident felt "down, ss", had trouble sleeping,	F 550		
Ĭ	antianxiety medication days a week. The physician's order documents the medicate release, 125 mg events to his anxiety disord Klonopin 0.5 mg at a day for anxiety was review of the MAR (er, signed and dated 11/12/17, ication Depakote tab, delayed ery day for behaviors related er. The physician's order for hite and 0.25 mg three times is igned and dated 2/21/18. A medication administration e staff documented the meds ered.			
3	evaluations for Resi	ontained two psychiatric dent #86 (4/9/18 & 5/24/18.) d consistent information			

concerning the resident's treatmen for depression and anxiety. The examiner documented the

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
- NATURAL CONTROL OF THE STATE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _	T	C 06/04/2018	
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ	160	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 550	and time. He judged adequate and intact The visiting mental he the medication there diagnosis for general recommened behaves were documented a "provide reassurance." The resident's CCP documented the residented to the surveyor intervifound to working with of the survey and semembers as well abconcerns. No one mental residented the re	and oriented to person, place his cognition skills to be mealth examiner agreed with apy as consistent with his blized anxiety. His ioral interventions to staff is "supportive listening" and e." (comprehensive care plan) ident with behaviors (refusing ith staff, calling 911, refusing name-calling staff and yelling), and providing doctor-ordered terventions before behavior calm voice, diversion, check erventions suggested by the "supportive listening" and e" were NOT in the resident's is. mented the resident was her and brother who both died 12/4/17 & 12/14/17 entions were included to help ith his grief and to sensitive to me. ewed every staff member the Resident #86 uring the time everal administrative staff rout his allegations and nentioned or acknowleged this or significant family members	F 550			

Christmas.

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DELLARGE	WEIGH OF HEALTH	IND HOMEN OF WHOLE			FURMIAPPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES	adic 4000		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER	No. 10 and 10 an	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010
	TO TIBELL STREET EIGH			SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	HAB		RTINSVILLE, VA 24112	
	OUT ALL PIVO	TITCHENT OF DEFINITIONS	3		
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DIBE COMPLETION
F 550	Continued From pag	ge 8	F 550		
	25 25	PM the facility administrator			
		or with a log of 911 calls			
		#86 to the local police			
	AN AN PARTY OF THE	lls included the situationbut			
	were not dated:				
	1. He needs to get b	back to his bed, he don't have			
	any legs.				
		not taking care of him, he			
	called for them and				
		tened and insulted by a nurse			
		was all up in his face and he			
	and the state of t	he refused to leave room			
	4. He needs his insu				
	5. He needs his me				
		cked blood sugar levels since			
	shifts changed.	ne's been laying there for four			
	hours without water	Bridge And September 100 Septe			
	8. No one will put hi				
		leaned all day and no one will			
	help him or his room				
	PLOT DESIGN DEC. THE RESERVE THE THE THREE	shed him up and he is just			
	laying there				
		gave his diabetic medicine			
	but did not give anx	iety and sinus med/ said she			
	left it on the cart and	d doesn't know what			
	happened to it.				
	The second secon	t diabetic medicine and hasn't			
	gotten it				
	16	him back in his bed, he's			
		keep walking by his room			
		ces, when he asks for help			
	270 to 10 to	ort-handed/he is tired of being			
	nasty				
	100	ole of the calls made from the			
		e were logged, but are thing over and over. The log			
	Dasically life Saffle	uning over and over, the log			

does indicate, that with 4 exceptions, all the 911 calls were made on or after December 15, 2017,

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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		С
NAME OF PE	ROVIDER OR SUPPLIER	433143		STREET ADDRESS, CITY, STATE, ZIP CODE	06/04/2018
				1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	HAB		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 550	Continued From page	n 0	E 55	^	2009
I= 550	252 554	other and brother expired.	F 55	U	
	On 5/29/18 at 5:50 P	M the resident was visited in			
		ined about the way he was			
		in the facility and that they			
	And the second s	ed at him when he requested ated, "(Name of CNA I) has			
	and the same of th	the supervisor (name not			
	- 12	peing no nasty. She won't			
		e up. (Name of CNA I) left and laughed at me. She said			
	Samuel Control of the Control of	that bellI'll come when I			
	NAMES	CNA IV) got so ugly one nite			
	she told me she "hop bed with no legs!"	ed to see me dead in that			
		weeping at this point with his			
		e said (Name of CNA I) is all. He stated, "I makes you			
		ng here sick and can't get			
		ater. I never thought I'd have			
		ey make me madl tell them ney treat me like a kid all the			
		always funny to them. They			
		norning hours and be			S
	laughing like fools."				7
	On 5/30/18 at 11:06 /	AM the facility resident			
		red about the staff's care and			
		124 spoke up and told the e CNAs are horrible to usl			
		y're short of help and they're			
		"The staff are nasty to us.			
	The contraction of the contracti	h cloth from the linen cart ring us any. If they see you			
		ch those rags' we need			

them!"

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		MEDICALD CERVICES			FORM APPROVED
	V SERVICE ACTIVITIES OF THE TOTAL OF THE TOT	MEDICAID SERVICES			OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND REN	HAB		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE COMPLETION
F 550	Continued From page	∋ 10	F:	550	
	any names of the offeresident #124 stated, them before. They no	members refused to give ending staff members. One "We've complained about ever respond to anything we feel like we're wasting our			
	about the staff's attitu said she never had a and noted that it was them that made a diff	M LPN II was interviewed ides towards resident. She ny trouble with the residents all how staff approached ference. If they're not in the , I come back at another treat somebody."			
		s a "cold fish" and could at times. She stated, "She s a chore."			
	she had not had any residentsbut knew s with them (Residents they're in a mood, I ju later when they don't	I CNA VII told the surveyor problems with some of the some aides had problems #5, & 86). If I go in and ust leave and come back mind having care done. a mood and want to be left			
	This information was administrator and DC	provided to the DN on 6/4/18 prior to exit.			
	This was a complaint	allegation deficiency.			
	Facility staff failed dignity and respect w	to treat Resident #5 with hile providing care.			

Resident #5 was admitted to the faciloity on 1/7/13. Her diagnoses included: Respiratory

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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 C 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 550 Continued From page 11 F 550 failure, chronic pain, neuropathy, anemia, heart failure, anxiety, depression, Schizophrenia, and chronic obstructive pulmonary disease. The latest MDS (minimum data set) assessment dated 5/22/18 coded the resident with fully intact communication and cognitive skills. Her memory was unimpaired. The resident's mood documented she had little interest in doing thing, felt down, depressed and hopeless, had sleeping issues, felt tired, felt bad about herself, and had trouble concentrating on things. The MDS documented the resident had no behaviors, hallucinations or delusions. She was not coded for physical, verbal or other behaviors towards staff or the other residents or her roomate. The resident was not coded for rejection of care. The MDS coded the resident with antianxiety and antidepressant medications 7 days a week. This resident was not coded with the administration of antipsychotic medications. The MDS documented the resident was very independent for the majority of ADLS (activities of daily living) but required the assistance of one staff member to help her dress and bath. The resident was totally continent of bowel, but was occasionally incontinent of bladder and required the assistance of one staff member for personal hygiene needs. She could walk to the toilet unassisted with her oxygen on.

Resident #5's CCP (comprehensive care plan) reviewed and revised 5/25/18 documented one page on her depression and the recommended interventions included offering her food and

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CENTER	\$ FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	1AB	1607	EET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET RTINSVILLE, VA 24112	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 550	changes were neede her feelings when she Resident #5's CCP in different inappropriate September 2013 until Some behaviors inclu ADL care and refusin Another behavior wa long." Different interview of the nursing two months didn't incinterventions were appropriately at 2:37 Pobserved to be laying speak to the surveyor resident told the surve they lie and treat you. The resident said ballate nite shift refused for her. The resident door and refused to the surveyor and refused to the surveyor the surveyor they lie and treat you.	telling her doctor if proving to see if medication d and taking time to discuss e was sad. Included nine pages with the behaviors dating from If the current time frame, aded shouting and refusing to change clothes, the structure of the past ficate any of the behavioral toplied/used. M Resident #5 was to in her bed. She sat up to the wor "I hate this place and	F 550		
100 000 1100	are happy, you are nend of this shift and yourse and CNA were notes as LPN III and	d sang and laughed, "We ot. We get to go home at the you're stuck here" The both identified and are in the CNA II. d to bring her a wash-cloth to wash my hands and face in			
	the morning. Some of	of them treat me bad and because the others told			

them to. The resident said she would really get into trouble if they found out she was talking to a

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	a coolings in the				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·
MARTINS	VILLE HEALTH AND RE	НАВ	1	SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 550	Continued From page	e 13	F 550		
	member of the survey	y team.			
	interview with Reside incidence when CNA she had radiation to hand the skin there rerof CNA II) was washin with me scrubbing my hurting me. She said continued." Resident #5 said she she came back in and crying, she didn't hurnever looked at her swas red or bruised. She stated, "I never this and be treated lik and talk about other when they're in here, not knowing who is goon 5/30/18 at 11:06 Acouncil was interview attitudes. Resident #5 surveyor "Some of the think it's because the irritable." Resident #33 stated, We'll go to get a was because they won't be	M the surveyor continued the ent #5. She told of another all was bathing her. She said her chest for breast cancer mained very tender. "(Nameing me and got too rough yichest. I told her she was all mot hurting you!" and asked, "Why are you to you!" Resident #5 said she will be was all was walked out the door. If I during this conversation, thought I'd be in a place like we this. They even come in residents like they're dogs and I walked out the staff's care and they are you all walked by and told the e CNAs are horrible to us! by're short of help and they're "The staff are nasty to us, he cloth from the linen cart wing us any. If they see you on't touch those rags' we			

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The resident council members refused to give

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	200 12	C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	НАВ	11	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET IARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEVENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 550	resident #124 stated, them before. They no complain about. We stomplain about. We stomplain about the staff's attitus aid she never had a and noted that it was them that made a diff mood to be bothered time. "It's all how you LPN II said CNA I wareally cop an attitude acts like everything is ON 6/3/18 at 7:30 PN she had not had any residents—but knews with them (Residents they're in a mood. I julater when they don't "Anybody can get in alone—I don't mind." On 6/4/18 the adminial findings prior to the This was a complaint 4. For Resident with dig to the Resident received.	ending staff members. One "We've complained about ever respond to anything we feel like we're wasting our I LPN II was interviewed des towards resident. She ny trouble with the residents all how staff approached ference. If they're not in the , I come back at another treat somebody." Is a "cold fish" and could at times. She stated, "She is a chore." If CNA VII told the surveyor problems with some of the some aides had problems if 5, & 86). If I go in and just leave and come back mind having care done. It mood and want to be left It deficiency. It deficiency It defic	F 550		
	to the Resident receifacility staff failed to i				

Resident #26 asked about the roommate she stated she was told what goes on-on the other side of that curtain is none of your business.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			1000	OMB	NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	ои	(X3) DATE SURVEY COMPLETED	
							С
- X		495143	B. WING				06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE		
MARTINS	/ILLE HEALTH AND REI	I AB		1607 SPRUCE S			
		A definition for section and report DRA CONTROL TO THE PROPERTY OF THE PROPERT		MARTINSVILL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	x (EA	PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	e 15	F:	550			
	had been admitted to Diagnoses included, peripheral vascular d kidney disease, and description C (cognitive properties of the set) assessment with reference date) of 03. (brief interview for most of 15. On 05/30/18 at approximate approximate expressed a control commate. Resident staff about the roomn on-on the other side of the	but were not limited to, isease, asthma, chronic diabetes. Datterns) of the Residents status MDS (minimum data an ARD (assessment /14/18 included a BIMS ental status) summary score eximately 5:00 p.m., Resident ne surveyors in the hallway cern regarding a new #26 stated she asked the nate and was told what goes of that curtain is none of your					
	this conversation. On 05/30/18 at appro	26 was visibly upset during ximately 5:40 p.m., during					
	admissions director s Resident with any kin	admissions director. The tated she did not provide the d of notice prior to the new ed in the Residents room.					
	administrator and cor	ximately 6:30 p.m., the porate nurse were notified g the Resident receiving a					
	interview with the sur	imately 5:55 p.m., during an veyor the Resident stated was getting a roommate					

and saw them in the bed.

and only found out when she entered her room

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

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CEMICK	S FUR WEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DE DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495143	B WING		06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0-1/2010
MARTINS	VILLE HEALTH AND RE	HAB	1	607 SPRUCE STREET	
			N	IARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 550	Continued From pag	e 16	F 550		
	administrator verbali admissions director I FRI (facility reported completed due to so	eximately 7:50 a.m., the zed to the surveyor that the nad been suspended and an incident) had been me comments she had made arding the Residents new			
	surveyor spoke with evening. Resident #2 been moved out of h	kimately 8:08 a.m., the Resident #26 about her 26 stated the roommate had er room and she had been Resident in the wrong room.			
	witness statements r Witness statement # when your getting a worry about B-side o A-side business." Wi part "she should or	ministrator shared copies of egarding this incident. 1 read in part "l can tell you roommate but you need to f the rooms and stay out of tness statement #2 read in haly be concerned with B-Bed room, and it's none of her out A-side."			
		n regarding this issue was by team prior to the exit			
F 557 SS=D		ht to have Prsnl Property)	F 557		
	§483.10(e) Respect The resident has a ri and dignity, including	ght to be treated with respect			
	possessions, includir	ght to retain and use personal ng furnishings, and clothing. lless to do so would infringe			

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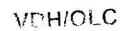
Event ID 56XM11

Facility ID. VA0159

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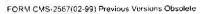
PRINTED: 06/19/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	9.8		C	MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	6	X3) DATE SURVEY COMPLETED
		738/75/77 F 12 724	Tone sections			С
		495143	B. WING	R B <u>R A111</u> 2		06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Œ	
MADTINE	VILLE HEALTH AND REI	IAD		1607 SPRUCE STREET		
MANTINO	VILLE REALTH AND REI	TAB		MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	(D PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	IX51 COMPLETION F DATE
E 557	Continued From page	2 17	E (557 1. Group re-education by Human	Racourcae	W10 W1 100
, 00,			F-4	and Director of Nursing in regard		7/4/2018
	(8)	alth and safety of other		service completed on 06/12/2018		
	residents.	To not mot an ovidenced		with staff. Staff required to comp		** ********
		is not met as evidenced		Learning Training Courses for Ro		hts.
	by:	n and staff interview, the		Customer Service, and Customer		
		naintain dignity for 2 of 45		Ombudsman to re-educate facility	y staff regard	ling
		ey sample (Residents #61		respecting the dignity of the resid		
	and #13).	y sample (residents #01		2. Residents that reside in the fac		
	a.i.e ii.e.j.			potential to be effected by this de		
	The findings included	t.		3. Group re-education by Directo		
	g-			Human Resources in regards to c completed on 6/12/2018 and 6/13		
	1. The facility sta	iff failed to provide dignity		required to complete Relias Train		
	during personal care			Resident's Rights, Customer Serv		
	Resident #61 was rea	admitted to the facility on		Service Essentials, Ombudsman		AND THE RESERVE TO SERVE TO SE
	2/2/13 with the follow	ing diagnoses of, but not		staff regarding respecting the dig		
	limited to anemia, der	mentia, seizure disorder.		facility. Patient Interview & Obs		
		ression, Schizophrenia and		(Dignity/Resident Rights) Audit t	to be comple	ted by
		Pulmonary Disease. On the		Social Service Director or Design		
		num Data Set) with an ARD		x 8 weeks to ensure facility staff	respects the o	dignity
	S	nce Date) of 4/18/18, the		of residents in the facility.	■ NO. 1. N.	2007
		is having a BIMS (Brief		4. Results of audits will be broug		Y.'
		Status) score of 3 out of a		quarterly Quality Assurance Performers (QAPI) Meeting fo		9
	regions and an extensive contract of the contr	Resident #61 was also		recommendations implemented a		
		y dependent on 2 staff		recommendations implemented a	5 marcarea.	
		s, bathing, personal care,				
	members for bed mo	ve assistance of 2 staff				
		n on 6/3/18 at 7:35 pm on				
	and the second s	rveyor observed a CNA #1				
		sistant) standing in the				
		#61's room. The CNA was				
	wearing gloves at this					
		the CNA then the CNA went				
	back into the residen	t's room. As the CNA was				
		room, she attempted to				
	close the door behind	her but it not close. The				
	surveyor stood in the	hallway and observed that				
	Resident #61 was lef	t exposed with no sheet or				

brief on. The CNA pulled the privacy curtain

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CENTER	S EOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
51.4 5.65	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CHA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER	A BUILDING	SNOTKOCTION	COMPLETED
		495143	B WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER		- 1	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	HAB		RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 557	Continued From pag	e 18	F 557		
	between the two bed	s but it only provided privacy			
	from the head of the	resident to the chest area.			
	Contraction of Contraction of Contraction of the Second State of Contraction of C	turn the resident away from			
		window with the resident			
		the bed. The surveyor moving the resident's brief			
	and exposed the res				
		n, the surveyor reviewed the			
		18/18, the resident was			
		y dependent on 2 staff rs and extensive assistance			
		or bed mobility. At the time			
		de the above documented			
	observation there wa				
		hen turning the resident in			
	the bed.				
	On 6/4/18 at approxi	mately 10 am, the surveyor			
	notified the corporate				
	documented findings	S.			
	The surveyor also no	otified the administrator and			
		the above documented			
	observation on 6/4/1				
		to the surveyor that that was			
		de care to any resident and dent was a 2 person assist.			
	capodany ii the reak	John Was a 2 person assisti			
	No further information	n was provided to the			
	surveyor prior to the	exit conference on 6/5/18.			
		staff failed to care for			
	resident #13 in such	n a manner as to promote the			
	Resident #13 was re	admitted to the facility on			



2/14/18 with the following diagnoses of, but not limited to high blood pressure, anxiety disorder,



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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		495143	B. WING _		C 06/04	1/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REF	HAR		STREET ADDRESS, CITY, STATE, ZIF 1607 SPRUCE STREET	CODE	
MARTING	WINDOWS TO THE TOTAL TOT			MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BF THE APPROPRIATE	rX5) COMPLETION DATE
F 557	Continued From page	e 19	F 5	557		
	failure. On the MDS ARD (Assessment Reresident #13 was cool Interview for Mental Spossible score of 15. On 6/3/18 at 7:40 pm Resident #13 was in surveyor if he could be surveyor verbalized to find a staff member the request. As the resident he was in, the subon the back of the whaccompanied the resurveyor asked the reconcerns with a brief the wheelchair when resident did not underwas saying so the surveyor asked the reconcerns with a brief the wheelchair. Resident back there." As the rethe surveyor, CNA (C) #1 came into the roo "Mr (name of that brief on the back resident became very screaming voice, "I don't want it there." If from the back of the in the trashcan.	hanging from the back of he was in the hallway. The erstand what the surveyor rveyor pointed to the brief he ed him if it bothered him to				

above document observation on 6/4/18 at approximately 10 am in the conference room.

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

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES		20 58	OWR NO	. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG	(X3) DATE COMPL	
		495143	B WING		06() 04/2018
NAME OF PE	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODI		34/2016
				1607 SPRUCE STREET		
MARTINS	VILLE HEALTH AND REF	1AB	ľ	MARTINSVILLE, VA 24112		
TO THE	CHEMADY CT	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COL	DDECTION	incasiii
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		I SHOULD BE	IX51 COMPLETION DATE
F 557	Continued From page	e 20	F 5	657		
	10 30	the administrator and		22 -		
		the above documented				
		m in the conference room.				
		ted, "I will take care of this				
		s caring for this resident last				
	night. This is not the	way we want our residents				
	to be cared for."			1. Call bells for residents #85 and	#77 placed within	
				reach immediately.	,	7/4/2018
	No further information			Resident #77, #86, #17, #101, #11	3, #63, & #26	
	and the sales of	exit conference on 6/4/18.		will have assessment completed by	y interdisciplinary	
F 558		odations Needs/Preferences	F 5	558 team to determine if side rails will	be considered a	
SS=E	CFR(s): 483.10(e)(3)			restraint or an enabler. If an enabl	ler is indicated,	
		ANNEXA MARINE POR CONTRACTOR AND ANNEXA MARINE A		therapy and clinical staff will try o		
		ht to reside and receive		to enablers to promote the highest		
	services in the facility accommodation of re			2. Residents that reside in the facil		
	preferences except w			potential to be effected by this def		
	N M	or safety of the resident or		3. Facility Management staff and l Nurse re-educated on 6/27/2018 b		
	other residents.	or ourou, or more recommen		Officer on the correct process to e		
		is not met as evidenced		side-rails and other needs and pref		
	by:			to consideration guidance from F6		
	Based on observation	n, resident and staff		F700 Side Rails with a focus on re		
	interview and clinical	record review the facility		for needs. Newly admitted residen	nts will be evaluated	
		ne accommodation of needs		by Interdisciplinary Team for use	of devices and	
		(Residents # 77, 86, 85, 17,		preferences.		
	101, 113, 63, & 26.)			Group re-education by Human Re		
	S			Director of Nursing in regards to o		
	~Residents #85 &77			and accommodation of needs compl		
	accessible call lights.			and 6/13/2018. Devices and Enab		
		17, 101, 113, 63, & 26 for e rails for bed mobility and or		reviewed in the weekly restraint n Audits to be completed by Depart		
	15	n asked for/requested by the		Designee daily per Care Keeper R		
	residents.	a donce to mequested by the		times 8 weeks to ensure the reside		
	rodidonto.			honored by facility.		
	Findings:			4. Results of audits will be brough	it to monthly/	
				quarterly Quality Assurance Perfo	70	
	1. Facility staff refuse	ed to let Resident #77 use		Improvement (QAPI) Meeting for		
		equested them and failed to		recommendations implemented as	s indicated.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						NO. 0938-0391	
	DEDEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) E	DATE SURVEY COMPLETED
20.000		495143	B. WING _		(Value		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	-	
MARTINS	MARTINSVILLE HEALTH AND REHAB				PRUCE STREET INSVILLE, VA 24112	903849	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFI; TAG	Κ	PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 558	Continued From page	e 21	F (558			
	place her call light wi	thin reach.					
	9/2/16. Her active dia hypertension, anemia disease, diabetes, va depression, chronic of disease, and weight l	a, peripheral vascular sscular dementia, anxiety, obstructive pulmonary loss. imum data set) assessment					
	The state of the s	cation ability, and intact					
	any issues with her n	was coded as not having nemory.					
	down, depressed or felling bad about hers	ed the resident as feeling hopeless, feeling tired and self. The resident was having any issues with his.					
	reviewed and revised resident as nervous a concerns were addre included, "If I don't lik something else" and the conversation or ta	prehensive care plan) If on 5/4/18 documented the and anxious at times. These essed with interventions that we what I am doing, let me do "If I'm upset, please redirect ask." The staff were hings that made the resident					
	council meeting, Res her siderails back. SI took them off the bed	PM during the resident sident #77 said she wanted he said they came in and d and now she is afraid to go ut the siderails. She stated, "I					

want mine back!"

She and the other four members of the group

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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 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRFFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DA"E REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 558 Continued From page 22 F 558 council said they had complained during the group on numerous occasions that they came in and took the side rails away from them. The attending members all said they wanted them back and knew of other residents that did too. They told the surveyor the facility staff had told them the STATE said they were against the law and they had to throw them all away. On 05/31/18 at 01:33 PM the surveyor walked into the resident's room to ask about her lunch. The resident was up in a wheelchair at the side of her bed. She sid she wanted to go back to bed--she'd been in wheelchair since before lunch. The resident stated, "I'm tired and I want to lay down." The surveyor asked her if she had used her call fight to summon facility staff to help her. The resident stated. "I cannot reach it." The surveyor observed the call light located on the other side of the bed and not within the resident's reach. The surveyor called LPN II into room and asked her about the call lite. LPN II put the call lite within reach of the resident and exited the room. On 5/31/18 at 2:50 PM the administrator and DON were informed of the issue regarding the siderails and the call lite. The administrator told the survey staff that the corporation had requested them to remove all side rails from the facility beds and the residents were not allowed to have them back.

back on his bed.

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2. Facility staff failed to provide Resident #86 siderails when he asked to have them placed

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER.	(X2) MULT A BUILDII	IPLE CONSTRUCTION	íX	3) DATE SURVEY COMPLETED
		495143	B WING			C
NAME OF PE	ROVIDER OR SUPPLIER	400140	1	STREET ADDRESS, CITY, ST/	NTE, ZIP CODE	06/04/2018
				1607 SPRUCE STREET		
MARTINS	VILLE HEALTH AND RE	HAB		MARTINSVILLE, VA 241	12	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUI L LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x (EACH CORREC CROSS-REFERFN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	IX5) COMPLETION DATE
F 558	Continued From pag	ge 23	F S	558		
	8/17/18. His admissi	dmitted to the facility on on diagnoses included: Complete amputation at and anemia.				
	The resident's latest MDS (minimum data set) dated 5/3/18 coded the resident with unimpaired communications skills. His cognitive ability showed slight memory impairment during testing. The same interview tasting indicated the resident					
		nt felt "down, depressed or ble sleeping, and had little				
	during the look back indicators for psycho physical, verbal or o documented. The re	the resident's behaviors period. The resident had no posis and no indicators for ther behavior symptoms sident was documented as every one to three days.				
	intervention of at lea the ADLs (activities was documented as set-up help only. Th	resident as requiring the list one staff member for all of daily living.) Resident #86 able to feed himself with e resident was incontinent of ider and required staff de care.				
	46-84 COVERNMENT CARROLL ACCRETED (5500) - 20-00 AND MADE (500)	M the resident was observed n with a guest. He introduced sister.				
	during this conversa "they" came in and	sked about his siderails ition. He told the surveyor that look them away because the gainst the law to keep them				

on the beds. The resident stated, I told them I

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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 C 495143 B WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY F 558 Continued From page 24 F 558 wanted mine back and the staff told me I'd never get them back." The resident then told the surveyor whenever he was rolled over in the bed for incontinence care he was afraid he was going to fall out of the bed. because part of his body was over the edge of the mattress. He stated, "I can't brace myself since the handrail is gone. I have to hang onto the headboard to keep from falling out of the bed." On 6/1/18 prior to the survey team exit, the administrator, and DON were informed of the resident's request. The administrator said they would put them back on his bed. 3. The facility staff failed to ensure that that the call bell remained within reach for Resident #85. Resident # 85 is an 89-year-old-female who was originally admitted to the facility on 8/9/07 with a readmission date of 5/31/11. Diagnoses included but were not limited to: hypothyroidism, heart failure, hypertension, and chronic pain. The clinical record for Resident #85 was reviewed on 5/31/18 at 9:35 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/2/18. Section C assesses cognitive patterns. In section C1000, the facility staff coded that Resident # 85's cognitive status as severely impaired. Section G assesses

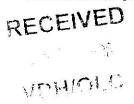
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functional status. In Section G0110, the facility staff documented that Resident #85 required extensive assistance with one-person physical assist for bed mobility, locomotion on the unit, dressing, eating, and personal hygiene. The facility staff also documented that Resident #85 was totally dependent requiring assistance of 2 or

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CENTERS FOR MEDICARE & MEDICAID SERVICES			1 200340		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL A BU'LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WiNG		C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав	12	STREET ADDRESS, CITY, STATE, 7IP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
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F 558	G0400, which assess range of motion, the Resident # 85 had not lower extremities. The current plan of conviewed and revised for "At risk for falls reassistance with mobincluded but were not personal items availated on 5/29/18 at 2:56 personal items availated on 5/29/18 at 2:56 personal items availated on 5/29/18 at 4:24 personal items availated on 5/29/18 at 4:24 personal items availated on 5/29/18 at 4:24 personal items availated on 5/29/18 at 5:41 personal items availated on 5/29/18 at 6:28 persona	sfers and bathing. In Section ses functional limitation in facility staff documented that o impairments in upper and sare for Resident #85 was don 5/9/18. The focus area elated to: Use of medication, ility," has interventions that of limited to "Call light or able and in easy reach." Inm., the surveyor observed in bed asleep. The call bell of time hanging off the top of ed touching the floor and was	F 558		

side of the bed touching the floor and was not

within reach of Resident #85.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	Scripture galaxy	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND RE	HAB	Appendix App	07 SPRUCE STREET ARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 558	No further information provided to the survey conference on 6/4/18 4. For Resident #17 accommodate Resident #17 accommodate Resident #17 was a originally admitted on 12/4/10. Admitting dinot limited to: major cataracts, contracture chronic pain, right leand diabetes mellitus. The most current Minassessment located Annual MDS assess Reference Date (AR coded that Resident #17 renursing care (4/3) w (ADL's). The facility	m, the administrative staff the findings as stated above. In regarding this issue was bey team prior to the exit Ithe facility staff failed to ent #17's needs and go the use of side rails. Regarding the who was in 11/24/09 and readmitted on agnoses included, but were depression, dysphagia, e of the right hand and wrist, go above the knee amputation in the clinical record was an ment with an Assessment D) of 3/5/18. The facility staff #17 had a Cognitive The facility staff coded quired extensive (3/2) to total with Activities of Daily Living staff coded that Resident tensive assistance of one) for	F 558		
	On May 30, 2018 at observed Resident # were observed on the hand splint on her righterviewed Resident that a few weeks ag	8:36 a.m., the surveyor #17 lying in bed. No side rails we bed. Resident #17 had a ght hand. The surveyor t #17. Resident #17 stated to the facility staff came in and ils. Resident #17 stated that			

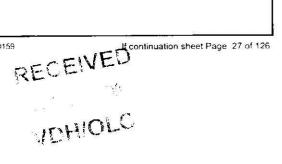
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she was able to assist with turning and

positioning when she had her side rails. Resident

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:	(X2) MULTIPI E CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER	Victorial Control of C	ST	REFT ADDRESS CITY, STATE, ZIP CODE	
MARTINS	/ILLE HEALTH AND REF	IAB	10000	07 SPRUCE STREET ARTINSVILLE, VA 24112	
(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)	
F 558	afraid of falling out of stated usually only on room to assist with he Resident #17 stated staff removed her side have them put back on On May 31, 2018 at 9 with the Director of No (Adm) and Corporate The surveyor notified (AT) that Resident #17 ago the facility staff caralls off the bed. The AT that Resident #17 able to assist with turnshe had the side rails notified the AT that Refelt safer when she had afraid of failing out of that a corporate execute move all side rails of The surveyor notified personal needs/prefel honored regarding he surveyor notified the Arails had limited Resident #17's and positioning. The secute that Resident #17 was afratherefore, her sense of compromised. Lastly that Resident #17's and been met, as Resident #17's and been met, as Resident #17's and been met, as Resident #18's and been met #18's and been met.	the staff turned her she was the bed. Resident #17 be staff member was in the er turning and positioning. She did not know why the erails and she would like to en her bed. 2:40 a.m., the surveyor met tursing (DON), Administrator Compliance Nurse (CCN). The Administrative Team 7 stated that a few weeks ame in and took her side surveyor also informed the stated that she had been ning and positioning when and positioning when the side rails, as she was the bed. The Adm stated utive gave a directive to the to a risk of entrapment. The AT that Resident #17's rences had not been are use of the side rails. The AT that removal of the side dent #17's bed mobility and is ability to assist with turning surveyor notified the AT that aid of falling out of the bed;	F 558		
	rails for turning and p	ositioning and for safety.			

On June 1, 2018 at 11 a.m., the surveyor observed Resident #17 lying in bed. The surveyor

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B WING		C 06/04/2018	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REF	HAB	1607	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETION	
F 558	bars on her bed. Res surveyor for getting the back on her bed. No additional informate exiting the facility as to accommodate Res needs regarding the up-	nt #17 had two small grab sident #17 thanked the ne side rails/grab bars put tion was provided prior to so why the facility staff failed ident #17's preferences and use of side rails.	F 558			
	admitted on 7/24/14. included, but were no disease (stage III), ur peripheral vascular d anxiety, chronic pain and schizophrenia.	t limited to: chronic kidney				
	Reference Date (ARI	nent with an Assessment D) of 4/18/18. The facility dent #63 had a Cognitive				

On May 30, 2018 at 3:26 p.m., the surveyor

inches and weighed 295 pounds.

Summary Score of 15. The facility staff also coded that Resident #63 required total nursing care (4/3) with Activities of Daily Living (ADL's). The MDS additionally coded that Resident #63 required extensive assistance of 1 (3/2) with turning and positioning while in bed. The MDS also coded in Section K. Swallowing and Nutritional Status that Resident #63 was 5 foot 5



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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		100	OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B WING	30	C 06/04/2018		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MARTINS	VILLE HEALTH AND R	EHAB	i i was	07 SPRUCE STREET ARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETION		
F 558	of the weight record #63 weighed 301 p. On May 30, 2018 a interviewed Reside that her side rails hed recently. Resimple woman. I have a bigger Resident #63 state inches of free space Resident #63 point she does not have and positioning. To Resident #63 was had only about 2-3 side of her bed. Resident #64 of falling out of the requested a bigger	#63's clinical record. Review documented that Resident	F 558				
	Resident #63 state not big enough for stated that she also back on her bed. On May 31, 2018 a with the Director of (Adm) and Corpora The surveyor notific (AT) that Resident came in and took is surveyor also infor stated she needed about 2-3 inches of her bed for turning informed the AT the	ad that she was told she was a larger bed. Resident #63 o wanted grab bars or side rails at 9:40 a.m., the surveyor met f Nursing (DON). Administrator ate Compliance Nurse (CCN). The side the Administrative Team #63 stated that the facility staff for side rails off the bed. The side the AT that Resident #63 is a bigger bed and only had off free space on each side of and positioning. The surveyor at Resident #63 was told she in to receive a larger bed. The					

Facility ID: VA0159

surveyor informed the AT that Resident #63 stated that she knew the facility had a larger bed

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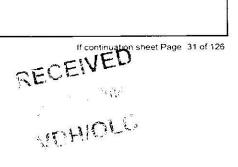
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	25		OMB NO. 0938-0391
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		495143	B. WING		C 06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	100	STREET ADDRESS, CITY, STATE, ZIP CO	
*******				1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND REI	148		MARTINSVILLE, VA 24112	
(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 C X (FACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE. COMPLETION OF APPROPRIATE DATE
F 558	the AT that Resident of the bed. The Admexecutive gave a direct due to a risk of entraphotified the AT that Reneeds/preferences have regarding her use of the bed. The surveyor not the side rails had limit mobility and limited heturning and positionin AT that Resident #63 the bed; therefore, he compromised. Lastly that Resident #63's anot been met, as Resident #63's anot been met, as Resident #63's anot been met, as Resident #63 lying in grab bars. Resident #63 Resident #63 lying in grab bars.	the surveyor informed #63 was afraid of falling out in stated that a corporate ective to remove all side rails oment. The surveyor esident #63's personal and not been honored the side rails and a larger otified the AT that removal of ted Resident #63's bed er ability to assist with ing. The surveyor notified the was afraid of falling out of er sense of safety had been on the surveyor notified the AT accommodation of needs had esident #63 wanted the side positioning and for safety and in the surveyor as room and observed a bariatric bed that had 2 #63 profusely thanked the inter a larger bed and the grab eation was provided prior to to why the facility staff failed sident #63's preferences and use of side rails and a larger in the facility staff failed to ent #113's needs and	F	558	
preferences regarding the					

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Resident #113 was an 86 year old female who was originally admitted on 6/28/11 and readmitted

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Facility ID: VA0159



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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495143			(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMP; FTED
		B. WING		C 06/04/2018	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	₩
MARTINS	VILLE HEALTH AND REI	нав		7 SPRUCE STREET RTINSVILLE, VA 24112	200
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDIBE COMPLETION
F 558	were not limited to: of fibrillation, acute respectively. The most current Minassessment located in Quarterly MDS assess Reference Date (ARI staff coded that Resident assistance (3/2) with (ADL's). The facility	diagnoses included, but ongestive heart failure, atrial piratory failure, osteoarthritis, propathy and hypothyroidism. In the clinical record was a assent with an Assessment D) of 5/18/18. The facility dent #113 had a Cognitive 4. The facility staff also #113 required extensive Activities of Daily Living staff additionally coded that red extensive assistance of	F 558		
	observed that Reside and dressed in street not observed any sid that the facility staff in Resident #113 stated why the facility staff in Resident #133 stated for turning and position that she was afraid of May 30, 2018 at 8:30 Resident #113 lying left. A Certified Nursi room and attempted bed for breakfast. The pull/position Resident	3:52 p.m., the surveyor ent #113 was lying on the bed tolothes. The surveyor did e rails. Resident #113 stated had removed her side rails. It she does not understand removed her side rails. It she needed the side rails oning. Resident #113 stated of falling out of bed. D. a.m., the surveyor observed in bed heavily leaning to the neg Assistant (C.N.A.) entered to pull Resident #113 up in the C.N.A. was unable to the red a Licensed Practical			

over to Resident #113's bedside to help the C.N.A. position Resident #113 in bed. The L.P.N. and C.N.A. had to lower the head of the bed,

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CENTERS FOR MEDICARE & MEDICAID SERVICES			1000		OMB NO. 0938-0391	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/04/2018	
	/ILLE HEALTH AND REI	НАВ		1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 558	lifting/pulling, pulled is sheet and position Resurveyor noted that the position Resident #11. On May 31, 2018 at 9 with the Director of N (Adm) and Corporate The surveyor notified (AT) that Resident #1 staff came in and too. The surveyor also information and positioning and positioning and positioning and positioning and positioning and her side rails out of the bed. The A executive gave a direct due to a risk of entrapnotified the AT that Reneeds/preferences have regarding her use of the notified the AT that relimited Resident #113 sability positioning. The surveyor and the refore, her sense to compromised. Lastly that Resident #113's had not been met, as side rails for turning a safety.	ser body mechanics for Resident #113 up with lift esident #113 in the bed. The ne process for staff to lift and lift in bed took 10 minutes. 2:40 a.m., the surveyor met tursing (DON), Administrator Compliance Nurse (CCN), the Administrative Team 13 stated that the facility k her side rails off the bed, ormed the AT that Resident had been able to assist with lift when she had the side dditionally notified the AT lated that she felt safer when as she was afraid of failing and stated that a corporate cive to remove all side rails orment. The surveyor resident #113's personal and not been honored the side rails. The surveyor moval of the side rails had lift bed mobility and limited by to assist with turning and leaver notified the AT that fraid of falling out of the bed; of safety had been the surveyor notified the AT accommodation of needs. Resident #113 wanted the land positioning and for	F 558			
	On .June 1, 2018 at	3:05 p.m. the surveyor				

observed Resident #113 being put to bed by C.N.A. The surveyor observed that the C.N.A.

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		ID HOMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDIN	PLF CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495143	B WING_		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/04/2018
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MARTINS	VILLE HEALTH AND REF	HAB		MARTINSVILLE, VA 24112	
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F 558	Continued From page	. 22	E E		
1 000			F 55	58	
		sident #113 in the bed. The esident #113 reached over			
		the left hand rail and assist			
	to pull herself over.				
	No additional informa	tion was provided prior to			18
		o why the facility staff failed			
	to accommodate Res	ident #113's preferences			
	and needs regarding				
	the state of the s	iled to provide reasonable			
	Resident #101 in rega	eds and preferences for ard to side rails.			
	3/1/18 with the following limited to anemia, confailure, high blood predictions of the following bloods. End Stage Fidepression. On the fidepression. On the fidepression of the fidepress	dmitted to the facility on ing diagnoses of, but not conary artery disease, heart essure, Peripheral Vascular Renal Disease, diabetes and MDS (Minimum Data Set) ment Reference Date) of was coded as having a for Mental Status) score of core of 15. Resident # 101 quiring extensive assistance dressing, personal hygiene endent on 2 staff members			
	surveyor on 5/31/18 a was observed to atter bed. The surveyor no having difficulty in doi Resident #101 if he n bed. The resident sta	re observation made by the at 11:15 am, the resident repting to turn over in the oted that the resident was ng this. The surveyor asked eeded any help in turning in ated, "They took my side d now it's hard for me to turn			

without using them." The resident further stated, "You should know all about that because I was told that there was a state law against having side

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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 C A. BU'L DING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND REI	НАВ		7 SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATFMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 558	Continued From page rails on the bed."	e 34	F 558		
	the above documents administrator stated, all side rails and disc not be considered a rewith bed rail entrapm asked the administrataken off the resident don't remember the ethe end of January at March." On 6/1/18 at 9:30 am Resident #101's room were put back on the resident stated to the yesterday and put the surveyor asked the reback on the bed help	the administrative team of ed findings at 4:15 pm. The "We were directed to look at ontinue them so they could restraint or have problems ent." The survey team tor when the side rails were 's beds and she stated, "I exact date but it began from and followed through to an and observed side rails resident's bed. The esurveyor, "They came in em back on the bed." The esident if having the bed rails led him in turning in bed. "Yes it does. It's easier			
	on 6/4/18 at 9:20 am the side rails that we between January 29 year. The surveyor a knew the exact date rails were moved from administrator stated, for you." The survey she could tell the roof #101 had been into sthe resident had bee	me into the conference room and provided a copy of all re assessed by maintenance the through mid - March of this asked the administrator if she that Resident #101's side on the bed. The "I don't have the exact date or asked the administrator if on numbers that Resident since January 29th because on discharged and then the facility several times			

Facility ID: VA0159

during the time frame the administrator had given to the survey team earlier in the discussion of the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						3 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
		495143	B WING				C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	, <u>, , , , , , , , , , , , , , , , , , </u>		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		3
MARTINS	VILLE HEALTH AND REI	НАВ			SPRUCE STREET TINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 558	Continued From page	e 35	F	558			
	side rails. The admir get back with you on	nistrator stated, "I will have to this."					
	8. For Resident #26.	n was provided to the exit conference on 6/4/18. the facility staff failed to exident in regards to bed					
	The record review re- had been admitted to Diagnoses included,	vealed that Resident #26 the facility 09/28/15. but were not limited to, isease, asthma, chronic					
	kidney disease, and						
	significant change in set) assessment with reference date) of 03 (brief interview for mi	patterns) of the Residents status MDS (minimum data i an ARD (assessment i/14/18 included a BIMS ental status) summary score ctional status) was coded to					
	totally dependent on and had no limitation upper extremity and the lower extremities alarms) was coded to	t required extensive ople for bed mobility, was two persons for transfers, in range of motion to the impairment on both sides in . Section P (restraints and o indicate the Resident did					
		regarding their bed					

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On 5/30/18 at approximately 6:15 p.m., during an interview with Resident #26 the Resident stated that the facility had taken away her bed rails (side

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Facility ID: VA0159

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CENTERS FOR MEDICARE & N	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
	495143	B WING		C 06/04/2018
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REH	IAB	160	FFT ADDRESS, CITY, STATE, ZIP COD 7 SPRUCE STREET RTINSVILLE, VA. 24112	DE .
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / 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 E APPROPRIATE DATE
over and up in the beckept me from being so bed rails restrained he and the facility staff has them remove them. On 05/31/18 at approximate a part of the removed a to put her call cord on floor. A review of the Reside (comprehensive care still included the interverguest she prefers the around bed rail." On 5/31/18 at 9:15 a. were notified by the separate and the facility over their bed rails/side administrator stated it related to restraints. During an interview we nurse) #3 on 06/01/18 p.m., LPN #3 stated to were more of a securibeing afraid. On 06/01/18 at approan interview with CNA #1. CNA #1 verbalize	d used them to pull herself d. Resident #26 stated they cared. When asked if the er in any way she stated no ad told her the state made eximately 8:08 a.m., Resident is a concern over her bed not that she had used them is so it would not fall in the	F 558		

expressed a concern when they were removed

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CENTER	S FUR WEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495143	B WING_		C 06/04/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARTINS	VILLE HEALTH AND RE	HAB		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATFMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 558	Continued From page	e 37	F 5	58	
	date when the Resid	s unable to provide an exact ents bed rails/side rails were t was sometime between 2, 2018.			
	assessment dated 12 facility staff had docu had a history of falls, mobility or difficulty in the side of the bed, had balance/poor trunk or rails for positioning a recommendations, the box beside the st	ontrol, is currently using side nd support. Under re facility staff had checked atement that read, "Side nd Serve as an Enabler to			
	During a meeting wit 06/01/18 at approxim administrator verbalize no assessments were removing the rails.	ately 4:00 p.m., the zed to the survey team that			
	provided to the surve conference.	n regarding this issue was by team prior to the exit			
F 559 SS=D	NESTERIOR DATE DIRECTO SERVICION PRODUCTION	of Room/Roommate Change r-(6)	F 5	59	
	or her spouse when	pht to share a room with his married residents live in the his spouses consent to the			
		ht to share a room with his hoice when practicable,			

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		THE SELECTION OF THE SE			OIND 110. 0000 0001
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER:SUPPLIER:CLIA IDENTIFICATION NUMBER	Delivered Volumes of	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		Programmer and an artist	1		C
		495143	B WING_		06/04/2018
NAME OF PROVID	DER OR SUPPLIER	~ × × × × × × × × × × × × × × × × × × ×	2005	STREET ADDRESS, CITY, STATE, ZIP CODE	587 ·
000177000000 - 20 - 1210224 01147007249603 - 2				1607 SPRUCE STREET	
MARTINSVILL	E HEALTH AND R	EHAB		MARTINSVILLE, VA 24112	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION;	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE DATE
¥6 38				e	

F 559 Continued From page 38

when both residents live in the same facility and both residents consent to the arrangement.

§483.10(e)(6) The right to receive written notice. including the reason for the change, before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:

Based on Resident interview, staff interview, and clinical record review, the facility staff failed to provide notice when the Resident received a new roommate.

The findings included:

The facility failed to provide the Resident with any notice written or verbal when the Resident received a new roommate.

The record review revealed that Resident #26 had been admitted to the facility 09/28/15. Diagnoses included, but were not limited to, peripheral vascular disease, asthma, chronic kidney disease, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 included a BIMS (brief interview for mental status) summary score of 15.

On 05/30/18 at approximately 5:00 p.m., the Resident stopped one of the surveyors in the hallway to express some concerns she had. One of these concerns was related to receiving a new roommate without any notice.

- F 559 1. Resident #26 notified in regards to receiving a new 7/4/2018 roommate. Staff member identified and received disciplinary action due to failure to provide dignity to resident #26.
 - 2. Residents that reside in the facility have the potential to be effected by this deficient practice.
 - 3. Staff re-education on F 559 Choose/Be Notified of Room/Roomate Change on 06:12:2018 and 06/13/2018, Patient Interview & Observation (Resident Rights) Audit to be completed by Social Service Director or Designee 5 times a week x 8 weeks to ensure facility staff provides notice to resident when receiving a new roommate.
 - 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495143	B WING		06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	50,800a.5. St.
MARTINS	VILLE HEALTH AND REI	НАВ		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(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 CORRI ((EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 559	Continued From page	e 39	F.5	559	
		eximately 5:40 p.m., during admissions director, the			
		rerbalized to the surveyor			
		de any kind of notice prior to g a new roommate. When			
		nmate arrived she stated			
	today about an hour	ago.			
	On 5/30/18 at approx	imately 5:55 p.m., during an			
		veyor the Resident stated was getting a roommate			
		hen she went into her room			
	and saw them in the	bed.			
	The state of the s	timately 6:30 p.m., the			
		porate nurse were notified goes no notification of the			
	Resident receiving a				
	On 5/31/18 at approx	timately 8:08 a.m., the			
	1,1700 p. 1500 p. 150 p	Resident #26 about her 26 stated the roommate had			
		er room and she had been			
	told they had put the	Resident in the wrong room.			
		n regarding this issue was			
	provided to the surve conference.	y team prior to the exit			
F 561	Self-Determination		F.S	561	
SS=D	CFR(s): 483.10(f)(1)-	-(3)(8)			
	§483.10(f) Self-deter				
		right to and the facility must e resident self-determination			
	through support of re	sident choice, including but			
	not limited to the righ (1) through (11) of th	ts specified in paragraphs (f) is section.			
	()	980,000 (1986) 985 (1986) 1877 (1986) 1878			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE COME	SURVEY PLETED
20 <u>10</u> 101		495143	B WING			C 04/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADTING	VILLE HEALTH AND REI	JAB	1	1607 SPRUCE STREET		
MAKTING	VICEL INCACITI AND REI	IAU		MARTINSVILLE, VA 24112		
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F 561	activities, schedules waking times), health care services consist assessments, and pla applicable provisions §483.10(f)(2) The reschoices about aspect facility that are significable facility that are significable facility. §483.10(f)(3) The reschibit facility. §483.10(f)(8) The resparticipate in other acreligious, and communiterfere with the right facility. This REQUIREMENT by: Based on observation interview and clinical determined the facility residents the choice (Resident #77). Findings: Facility staff failed to her room when she coresident's clinical recent 3:00 PM.	ident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make sof his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the dividities, including social, inity activities that do not its of other residents in the record review it was a staff record review it was a staff failed to allow 1 of 45 of eating in her room allow Resident #77 to eat in hose to do so. The ord was reviewed on 5/30/18 mitted to the facility on	F 56	1. Dietary Manager met with resident to preferences and it was noted that reside at in her room. Social Services Direct resident to ensure there were no psyche behaviors that was leading to self isola 2. Residents that reside in facility have to be effected by this deficient practice 3. Staff re-education on Self Determina Human Resources and Director of Nursto customer service completed on 6/12/6/13/2018. Group re-education by Human Resource Director of Nursing in regards to custo completed on 6/12/2018 and 6/13/2018 Staff required to complete Relias Learn Courses for Resident Rights. Customer and Customer Service Essentials. Patient Interview & Observation (Dign Resident Rights) Audit to be completed Social Service Director or Designee 5 ox 8 weeks to ensure residents are given of where they prefer to eat. 4. Results of audits will be brought to 1 quarterly Quality Assurance Performar Improvement (QAPI) Meeting for revirecommendations implemented as indi	ent prefers to or interviewed ological tion. the potential tion by sing in regards (2018 and the service and the service and the service and the service are service. I by times a week the choice the monthly the service and the service and the service are the choice the service and the service and the service are the service are the service and the service are the	7/4/2018

hypertension, anemia, peripheral vascular

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	M WO MO	<u> </u>		OMB N	O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ULIA IDENTIFICATION NUMBER.	(X2) MULT A BUILDIN	IPLE CONST	RUCTION		E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	3 <u>1</u>		STREET	ADDRESS, CITY, STATE, ZIP CODE	1 0.	3,04/2010
MADTING	VILLE HEALTH AND RE	HAR		1607 SPI	RUCE STREET		
MARTING	VILLE HEALTH AND KE	TIAD .		MARTIN	ISVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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)	l D BE	(X5) COMPLETION DATE
F 561	Continued From pag	e 41	F 5	561			
	N (7)	ascular dementia, anxiety,	1: ,-				
		obstructive pulmonary					
	disease, and weight	loss.					
	The latest MDS (min	imum data set) assessment					
	dated, 4/25/18, code						
	unimpaired commun						
	any issues with her r	was coded as not having memory.					
		,					
		ed the resident as feeling					
	The California of Secretary Control of the Secretary Control of the Sec	hopeless, feeling tired and self. The resident was					
		naving any issues with					
	psychosis or delusio	ns.					
	The latest CCP (con	prehensive care plan)					
	reviewed and revised	d on 5/4/18 documented the					
		and anxious at times. These essed with interventions that					
		ke what I am doing, let me do					
		"If I'm upset, please redirect					
	the conversation or t						
	instructed to "avoid t more anxious."	hings that made the resident					
	more analogs.						
		ers signed and dated 1/8/18					
	documented a preso	ription for Depakote o times daily for behavior.					
		y day was ordered on 9/2/16.					
	A review of the MAR	(medication administration					
		the medications were					
	provided as ordered	į.					
	On 5/30/18 at 12:15	PM Resident #77 was in the					
	dining room and sea	ted at the table with peers.					

When the food trays start coming out of the kitchen a staff member grabbed the resident's wheelchair and wheeled her back to south unit

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CENTER:	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER-	(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER		STRFF	FT ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010
MARTINS	VILLE HEALTH AND REF	I AB		SPRUCE STREET FINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 561	CNA VI & II) on either The surveyor asked wout of the dining room she eats second lunch dining room and water both started laughing "why would the resident #77 looked wanted to eat her lun surveyor could reply, stated. "You don't wa wanna stay out here." Both CNAs were laugher everytime she tried dipped head looking and looked defeated. resident again if she want to eat in my roo. The two CNAs contin CNA VI stated, "I'll see eat in your roombut dining room." The surmembers if the resident said, yes.	why the staff had moved her and CNAs VI & II both said the and just likes to sit in the she everybody else eat. They at this point and saying ent want to do that?" at surveyor and said she ch in her room. Before the the CNAs laughed CNA VI into go to your roomyou with us." whing and talking over top of ed to respond. The resident eat the floor, pursed her lips. The surveyor asked the wanted to eat lunch in room up and said. "Tearfully, yesI m." ued to chortle and laugh and se if your nurse will let you you're supposed to go to reeyor asked the staff ent could feed herself. They weeked the CNAs why the nurse's permission to eat in	F 561		
	When second lunch of	came the resident was			

eat there--unassisted.

observed to be back in the dining room and left to

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PRINTED: 06/19/2018 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 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (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 DATE DEFICIENCY) F 561 Continued From page 43 F 561 At 1:45 PM resident observed to be laying in bed. She was asked how it made her feel when we had the meeting at the unit table. She stated, "I didn't like it much--you could see I just got quiet and wouldn't speak to them anymore." Resident #77 said the CNAs hurt her feelings when they laughed at her. On 5/30/18 at 4:00 PM the DON was informed of the findings. She said if the resident wanted to eat in her room, she should be allowed to. F 565 Resident/Family Group and Response F 565 1. Previous resident council meeting pulled and 7/4/2018 follow up concern forms filled out and addressed SS=E CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) with each resident involved. Concern resolutions §483.10(f)(5) The resident has a right to organize discussed with residents with concerns within 5 and participate in resident groups in the facility. days. (i) The facility must provide a resident or family 2. Residents that reside in the facility have the potential to be effected by this deficient practice. group, if one exists, with private space; and take 3. Staff members re-educated regarding completing reasonable steps, with the approval of the group, concern forms within 5 days and resolution is to make residents and family members aware of discussed with resident and/or resident's representative. upcoming meetings in a timely manner. Patient Interview & Observation (ii) Staff, visitors, or other guests may attend (Dignity/Resident Rights) Audit to be completed by resident group or family group meetings only at Social Services Director and/or Designee 5 x a week the respective group's invitation. x 8 weeks to ensure facility staff responds to (iii) The facility must provide a designated staff complaints and/or grievances expressed by the person who is approved by the resident or family resident council members. group and the facility and who is responsible for 4. Results of audits will be brought to monthly! providing assistance and responding to written quarterly Quality Assurance Performance requests that result from group meetings. Improvement(QAPI) Meeting for review and (iv) The facility must consider the views of a recommendations implemented as indicated. resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life

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in the facility.

(A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every

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Facility -D. VAG159

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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 C 495143 B WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 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) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 565 Continued From page 44 F 565 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced Based on resident and staff interview and resident council meeting minutes review it was determined the facility staff failed to respond to complaints and/or grievances expressed by the facility Resident Council Members. Findings: On 05/30/18 at 11:49 PM during the resident council meeting, Resident #77 said she wanted her siderails back. She said they came in and took them off the bed and now she is afraid to go to sleep at nite without the siderails. She stated, "I want mine back!" She and the other four members of the group council said they had complained during the group on numerous occasions that they came in and took the side rails away from them. The attending members all said they wanted them back and knew of other residents that did too. They told the surveyor the facility staff had told them the STATE said they were against the law

and they had to throw them all away.

The surveyor reviewed the group council minutes and determined that the residents had submitted

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A BUILDING	DISTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ	1607	EET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET RTINSVILLE, VA 24112	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 565	been addressed by sone of those issues. issue that had not be On 5/30/18 at 11:06 acouncil was interview attitudes. Resident # surveyor "Some of the think it's because the irritable." Resident #33 stated, We'll go to get a was because they won't be they holler at you, 'do need them!" The resident council any names of the offe Resident #124 stated them before. They not complain about. We is breath. The administrator and above on 5/31/18 at a said the company has siderails and no resident bed. The administrator tole following day that the had not been filled out.	a their meeting that had not taff members. Side rails was Staff attitudes were another en addressed. AM the facility resident red about the staff's care and 124 spoke up and told the e CNAs are horrible to usI ry're short of help and they're "The staff are nasty to us. In cloth from the linen cart raing us any. If they see you on't touch those rags' we rembers refused to give ending staff members. If, "We've complained about ever respond to anything we feel like we're wasting our delined by the decided to dispose of all dent was allowed to use them the difference of the eresident complaint forms at and reported to the	F 565		
	when they took minu	y the activities department tes for the meetings. The e had inserviced the staff			

about filling out the complaint forms and would address the resident's concerns in council going

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE COMPI	
		495143	B. WING _			06/0) 04/2018
NAME OF P	ROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		STREET ADDRESS, CITY, STATE, ZIP COD	Ε		
MADTING	VILLE HEALTH AND REA	IAD		1607 SPRUCE STREET			
MAKTING	VILLE NEACHT AND REF			MARTINSVILLE, VA 24112			
(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		(X5) COMPLETION DATE
F 565	Continued From page forward.	e 46	F5	65			
F 500		did noticelly of Donords	г (с	83 1. MDS Scoop Sheet immediately	removed f	from the	7/4/2018
	CFR(s): 483.10(h)(1)	nfidentiality of Records -(3)(i)(ii)	FC	nursing station and placed on a cl cover sheet.			
	§483.10(h) Privacy ai	nd Confidentiality		2. Residents that reside in the faci	lity have th	1e	
	· · ·	the confidentiality. The personal privacy and		potential to be effected by this det	ficient prac	tice.	
	(in	or her personal and medical		3. Facility staff to be re-educated	180		
	records.			Privacy/Confidentiality of Record Nursing and/or designee. Care Ko	eper Roun	d Audits	
	§483.10(h)(l) Persona	al privacy includes		to be completed by Department H		week	
		dical treatment, written and		x 8 weeks to ensure facility staff;	Married Married Laboratory	out to our	
	telephone communica	ations, personal care, visits,		confidentiality of a resident's pers records.	onal and in	icaicai	
	and meetings of fami	ly and resident groups, but		4. Results of audits will be brough	nt to month	dv/	
	this does not require	the facility to provide a		quarterly Quality Assurance Perfo		11. y 7	
	private room for each	resident.		Improvement(QAPI) Meeting for recommendations implemented as	review and		
	§483.10(h)(2) The fac	cility must respect the		recommendations impresiented u.	, marcatea.		
	residents right to pers	sonal privacy, including the					
		or her oral (that is, spoken),					
	written, and electronic	c communications, including					
		promptly receive unopened					
	mail and other letters	The state of the s					
		the facility for the resident,					
	A-70 (A) 100 (A)	ered through a means other					
	than a postal service.						
	§483.10(h)(3) The res	sident has a right to secure					
		onal and medical records.					
		ne right to refuse the release					
	of personal and medi						
)(2) or other applicable					
	federal or state laws.	Ü					
		llow representatives of the					
		ng-Term Care Ombudsman					
		t's medical, social, and					
	administrative record	s in accordance with State					

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

This REQUIREMENT is not met as evidenced

Event ID: 56XM11

Facility ID: VA0159

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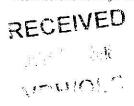
PRINTED: 06/19/2018 FORM APPROVED

OCNTER	O FOR MEDICARE A	MEDICAID SERVICES			OND NO 2020 2024
		MEDICAID SERVICES		1.3 (0.40)	OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING	nome company of the	C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	-1 -2 -1
MADTING	WILE HEALTH AND BEI	HAD	160	7 SPRUCE STREET	
MAKIINS	VILLE HEALTH AND REI	пав	МА	RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPROPERTION OF T	JLD BE COMPLETION
F 583	by: Based on observation facility staff failed to president's personal a 3 units in the nursing. The findings included. The facility staff failed a resident's medical into board lying on top of sight of anyone that we contained medical into On 6/3/18 at 8:05 pm the nurses' station arplain sight on the top information on 20 resepatio Unit. At the top titled "MDS (Minimum Date: 6/1/18). The surveyor reques Nurse) #1 to come to looked at the top of the dask." That she don't know who put it keep it down here (puthe desk)." The surveyor and then ple clipboard but added. The surveyor notified.	on and staff interview, the provide confidentiality of a and medical records on 1 out facility (Patio Unit).	F 583		
	pm. No further informatio	n was provided to the			

surveyor prior to the exit conference on 6/4/18.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	8	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		1 3 Law 1 3	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010
				1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	HAB		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 584	Continued From page	o 18	Esc	24 1 21	d/arassura 7/4/2018
F 584	EA 2007	able/Homelike Environment		 34 1. Shower rooms have been power serubbe 34 washed, shower curtains have been wiped of 	d/pressure
	CFR(s): 483.10(i)(1)-		rac	floors swept.	town and
JU-L	σ <u>(</u> σ./	V-32		Bathroom was thoroughly cleaned to include	ling
	§483.10(i) Safe Envir	ronment.		removing the ring in the toilet.	274
	The resident has a rig	A STATE OF THE STA		2. Residents that reside in the facility have	
		nelike environment, including		potential to be effected by this deficient pra	
	but not limited to rece			 Weekly power scrubbing will take place floors and walls. Shower curtains will be v 	
	supports for daily living	ng sately.		daily during the cleaning completed by hou	
	The facility must prov	vide-		assigned to each shower room.	
	FOR DESIGNATION AND CONTRACTOR OF THE STANDARD AND A CONTRACTOR OF	clean, comfortable, and		Housekeeping staff re-educated by District	
		nt, allowing the resident to		on 06/15/2018 regarding deep cleaning sho	wer rooms
	use his or her person	nal belongings to the extent		and resident room bathrooms. Housekeeping Shower Room/Bathroom Au	rdite will
	possible.			be completed by the housekeeping manage	
		uring that the resident can		designee 5 x week x 8 weeks and record an	
		vices safely and that the		needing attention on the monitoring form.	
		e facility maximizes resident		items needing attention will be reported to	the
		oes not pose a safety risk. exercise reasonable care for		appropriate staff member.	
		resident's property from loss		4. Results of audits will be brought to mont	hly/
	or theft.			quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review a	nd
				recommendations implemented as indicated	
	1654 2101317 A	ceeping and maintenance			
		o maintain a sanitary, orderly,			
	and comfortable inter	rior;			
	8483 10(i)/3) Clean b	ped and bath linens that are			
	in good condition;	yes and bath interio that are			
		closet space in each			
	resident room, as spo	ecified in §483.90 (e)(2)(iv);			
	§483.10(i)(5) Adequa	ate and comfortable lighting			
	levels in all areas;				
		table and safe temperature			
		ally certified after October 1,			
	1990 must maintain a	a temperature range of 71 to			



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DÉFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	el (re-	C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	30° 45 5c.	STR	FFT ADDRESS, CITY, STATE, ZIP CO	DE
MARTINS	VILLE HEALTH AND REI	НАВ	100 May	7 SPRUCE STREET RTINSVILLE, VA 24112	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMP. FTION IE APPROPRIATE DATE
F 584	Continued From page 81°F; and	e 49	F 584		
	sound levels. This REQUIREMENT by: Based on observatio staff interview, the factlean, comfortable, a	maintenance of comfortable is not met as evidenced on, Resident interview, and cility failed to maintain a nd homelike environment on nd for one of 45 Residents.			
,	units were observed brown substance on	on the north and south by the surveyor to have a the shower chairs. The patio s observed to have debris in			
	an interview with Res	eximately 5:55 p.m., during sident #26 the Resident regarding the shower rooms			
	surveyor and CNA (centered shower room surveyor observed a brown substance on stated it looked like "had been told not to a leak and there had However, no sign waduring this observation then proceeded to shower them.	oximately 8:15 a.m., the sertified nursing assistant) #1 in #1 on the south unit. The moderate amount of a the shower chair. CNA #1 poop." CNA #1 stated they use this shower room due to been a sign on the door on. The surveyor and CNA #1 nower room #2 "beauty isservation, the surveyor was			

able to observe a small brown spot in the floor of

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DEFARTI	MENT OF DEALTH AN	ID HOMAIN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DEDEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIS A. BUILDIN	PLF CONSTRUCTION.	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	1 00/04/2016
MADTINE	VILLE HEALTH AND REA	JAD.		1607 SPRUCE STREET	
MAKIINS	VILLE REALIH AND REP	1AD		MARTINSVILLE, VA 24112	
(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 APPROPRICIENCY)	DBE COMPLETION
F 584	Continued From page	∍ 50	F 5	34	41
	On 06/01/18 at appro	eximately 8:25 a.m., the			
		censed practical nurse) #2			
		oom on the north unit and			
		a moderate amount of a the shower chair. LPN #2			
		needed to be cleaned.			
	en vienz mine				
		eximately 8:30 a.m., the shower room on the patio			
	-	as able to observe a blue			
		small area at the back of this			
	The housekeeping m issues in the shower	anager was notified of the room on 06/01/18.			
	On 06/01/18 at appro	eximately 4:00 p.m., during a			
		ey team the administrator,			
		sing), and nurse consultant successives regarding the shower			
	rooms.	sucs regarding the shower			
	provided to the surve	n regarding this issue was y team prior to the exit			
	conterence. 2. For Resident #92 t	the facility staff failed to			
S.		ortable, homelike and well			
3	maintained bathroom	Let			
1	Resident #92 was an	85 year old male who was			
		Admitting diagnoses			
		ot limited to: dehydration, e with collapse, psychosis,			
		nur, fractured humerus and			
	depression.				

The most current Minimum Data Set (MDS) assessment located in the clinical record was a

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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.	4X2; MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	B E E ROOM	C 06/04/2018
	ROVIDER OR SUPPLIER	H AB	160	EET ADDRESS CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION
F 584	Medicare 30 Day MD Assessment Referent The facility staff code Cognitive Summery Salso coded that Residuals assistance (3/2) with (ADL's).	S assessment with an ce Date (ARD) of 5/5/18. d that Resident #92 had a Score of 3. The facility staff dent #92 required extensive Activities of Daily Living	F 584		
	noted that the bathrood rooms. The rooms had room. The bathroom residents. The surve and observed that two and the florescent light broken. The surveyo toilet bowl had a brow the commode. Lastly,	yor observed the bathroom of ceiling tiles were stained on the ceiling was or also observed that the vincircle at the water line of the surveyor observed that seat was badly rusted and			
	met with the Administ Nursing (DON) and C (CCN). The surveyor Team (AT) that Resid well maintained or cle the AT that the bathro the florescent light fix raised toilet seat was Lastly, the surveyor n	250 p.m., the survey team crator (ADM). Director of corporate Compliance Nurse of notified the Administrative ent #92's bathroom was not ean. The surveyor notified from had broken ceiling tiles, ture was broken and that the badly rusted and dirty. Notified the AT that the part ring of debris at the water			
		tion was provided prior to to why the facility staff failed			

to ensure a clean, comfortable and homelike

environment for Resident #92.

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
II 4 4		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	120 100 100 100 100 100 100 100 100 100	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING_		C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRESS, CITY. STATE. ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI L LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD B CROSS REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	nents	F 64	 1 1. Resident #10's MDS assessment modified 5/31/2018 for accurate coding regarding the vaccine. 	
	resident's status. This REQUIREMENT by: Based on staff interv review, the facility sta	of Assessments. It accurately reflect the It is not met as evidenced liew and clinical record If failed to maintain an		2. Residents that reside in the facility have the potential to be effected by this deficient practs. MDS staff to be re-educated by the Vice I of Clinical Reimbursement regarding accurates Assessments to ensure compliance with MD (Minimum Data Set) Accuracy and coding of O of the MDS. Administrator and/or Design audit Comprehensive Assessments complete	etice. President acy of S of Section ee to

The findings included:

(Resident #10)..

The facility staff failed to complete an accurate MDS in regards to Resident #10's flu vaccine documentation.

on 1 of 45 residents in the survey sample

Resident #10 was admitted to the facility on 1/30/16 with the following diagnoses of, but not limited to anemia, stroke, seizure disorder, anxiety disorder, depression and Psychotic Disorder. On the annual MDS with an ARD (Assessment Reference Date) of 3/2/18, the resident was coded as having short term and long-term memory problems. Resident #10 was also coded as requiring extensive assistance of 2 staff members for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 2 staff members for bathing.

The surveyor performed a review of Resident #10's clinical record on 5/30 and 5/31/18. During this review, the surveyor noted on the MDS with ARD of 10/13/17, under Section O 0250, the flu vaccine was documented as being given on 9/14/16. On the next MDS with ARD of 1/3/18 under Section O 0250, the flu vaccine was

- facility 5 x week x 8 weeks to ensure facility staff maintain accurate MDS (Minimum Data Set) Comprehensive Assessments for residents in the facility.
- 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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Event ID: 56XM11

Facility ID: VA0159

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CTITELIEUT	and compression of the second	TIEDIOAID SERVICES		OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
		495143	B. WING	C 06/04/2018
	PROVIDER OR SUPPLIER	1AB	STREET ADDRESS, CITY, STATE, ZIP C 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO 1 DEFICIENCE	FION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 641	MDS nurse #1 of the for Resident #10 in re of when the flu vaccin nurse #1 stated, "Let and then I will be back At 3:45 pm, MDS nurse conference room and copy of the MDS with had made a correction. The MDS nurse #1 st. correct date when I w	n, the surveyor notified the above documented findings gards to the documentation e was given. The MDS me go back and look at this k to talk to you." se #1 returned to the provided the surveyor a ARD of 10/13/17 that she in under Section O 0250. ated, "I just overlooked the as coding the MDS. But of the modification that I	F 641	
F 656 SS=D	the above documented 4:00 pm in the conference 5:00 pm in the conference plan for each result of conference 5:00 pm in the conference plan for each result of conference plan f	was provided to the xit conference on 6/4/18. omprehensive Care Plan nsive Care Plans lility must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and ludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must	1. Comprehensive Care Plan for updated on 5/30/2018 with a car ulcers and Discharge to Commu 2. Residents that reside in the far potential to be effected by this of 3. MDS Staff to be re-educated Implementing Comprehensive Covice President of Clinical Reims Staff also completed Relias Lea Care Planning and Implementat Planning in Long Term Care. MDS Coordinator and/or design Comprehensive Care Plans 5 x of the facility develops complete Comprehensive Care Plans 6 x of the facility develops complete Comprehensive Care Plans 6 x of the facility develops comprehensive Care Plans 6 x of the fa	re plan for pressure unity Plan. acility have the deficient practice. regarding Development: Care Plans by the abursement. MDS aming training on tion and Care nee to audit completed week x 8 weeks to ensure Comprehensive Care Plans. aght to monthly/quarterly Emprovement

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495143	B WING_		C 06/04/2018
	ROVIDER OR SUPPLIFR	нав		STREET ADDRESS CITY STATE Z 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETION
F 656	or maintain the reside physical, mental, and required under §483.3 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, includ treatment under §483.10, includ treatment under §483.6 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv) In consultation wit resident's representa (A) The resident's good desired outcomes. (B) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff interview it was determifailed to develop a Cot of 45 Residents in the #92.	are to be furnished to attain ent'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 ding the right to refuse 8.10(c)(6). ervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and efference and potential for illities must document as desire to return to the essed and any referrals to s and/or other appropriate	F6	56	

a Comprehensive Care Plan (CCP) to include a

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1900		OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2; MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100/100/00 M/1047	******************		С
		495143	B WING	(a) Management (a)	06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS CITY, STATE, ZIP CODE	
544 DTIMO	ALLE MEALTH AND DE	(IAD	160	7 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	пав	MA	RTINSVILLE, VA 24112	24/220
(X4) ID PREFIX TAG	(EACH DEFICIENT	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)	LD BE COMPLETION
F 656	Community Plan as Minimum Data Set (re 55 Ire Ulcers and a Discharge to identified on an Admission MDS) assessment with an ince Date (ARD) of 4/13/18.	F 656		
	The findings include				
	Resident #92 was an 85 year old male who was admitted on 8/19/17. Admitting diagnoses included, but were not limited to: dehydration, hypotension, syncope with collapse, psychosis, fracture of the left femur, fractured humerus and depression.				
	assessment located Medicare 30 Day M Assessment Refere The facility staff cod Cognitive Summery also coded that Res	inimum Data Set (MDS) in the clinical record was a DS assessment with an nce Date (ARD) of 5/5/18. ed that Resident #92 had a Score of 3. The facility staff ident #92 required extensive n Activities of Daily Living			
	reviewed Resident at the clinical record plassessment with an staff coded on the Alfacility staff also coorequired extensive a of Daily Living (ADL documented in Secretary Park 192 had a wheelchair pressure the application of oi	9:30 a.m., the surveyor #92 clinical record. Review of roduced an Admission MDS ARD of 4/13/18. The facility dmission MDS that Resident e Summary Score of 3. The Bed that Resident #92 assistance (3/2) with Activities (s). The facility staff also tion M. Skin Conditions that skin tear, used a bed and e reducing surface and had intments/medications to areas In Section Q. Participation in			

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Assessment and Goal Setting 0400. Discharge

Event ID: 56XM11

Facility ID: VA0159

If continuation sheet Page 56 of 126



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BÜLDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495143	B WING	Marie Ma	06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY STATE, ZIP CODE	
			10	607 SPRUCE STREET	
MAKIINS	VILLE HEALTH AND REF	146	M	IARTINSVILLE, VA 24112	
(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 (FACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROFILE DEFICIENCY)	DIBE COMPTE, ON
######################################	Continued From page Plan the facility staff of an Active Discharge Referral. In Section Assessments (CAA's for Pressure Ulcers at Referral. The facility Care Plan (CP) would "triggered" areas of Pto Community. Continued review of the Comprehensive Continued review of the Comprehensive Continued a CP for Presto the Community Plant On May 30, 2018 at Strequested to speak to few moments the MC Registered Nurse (RI The surveyor reviews the ARD of 4/13/18 was surveyor specifically #92 "triggered" for Propinted out that the fothat a CCP would be Ulcers and a Dischars surveyor then review Nurse. The surveyor	documented that there was Plan to Return to the on V. Care Area) Resident #92 "triggered" and Return to Community staff documented that a dibe developed for the Pressure Ulcers and Return the clinical record produced Care Plan (CCP) that was eview of the CCP failed to essure Ulcers or a Discharge and the MDS Nurse. Within a DS Nurse, who was a N), approached the surveyor ed the Admission MDS with with the MDS Nurse. The pointed out that Resident	F 656		PRIATE DATE
	stated that she did no been developed to in Ulcers and a Dischar	unity Plan. The MDS Nurse of know why a CCP had not occlude a CP for Pressure ge to Community Plan. 2:50 p.m., the survey team			

met with the Administrator (ADM), Director of Nursing (DON) Corporate Compliance Nurse

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL A BUILDING	F CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495143	B WING	N. W. 4 (1980) (1774)	06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER	ar a		STREET ADDRESS, CITY STATE ZIP CODE	***
MARTINS	ILLE HEALTH AND RE	IAR		1607 SPRUCE STREET	
W. C.	TIELE TIEMENT AND THE			MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 656	Team (AT) that the fa CCP to include Press Plan to Return to Cor Admission MDS with No additional informa exiting the facility as to develop a CCP for	notified the Administrative cility staff failed to develop a sure Ulcers and a Discharge nmunity as identified on an	F 65		
F 657 SS=E	Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an inincludes but is not lin (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prather esident and the An explanation must medical record if the and their resident reprot practicable for the resident's care plan. (F) Other appropriate	ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to	F 65	7 1. Residents #82, #93, #49, and #26 remain facility. Care Plans have been revised to ref current eare needs. Resident #268 is a close review and has expired. No correction made plan. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. Interdisciplinary Team re-educated by Viv President of Clinical Reimbursement on 6/2 regarding Care Plan Timing and Revision. Facility staff to be re-educated by Director of and/or designee regarding comprehensive caplanning and care plan timing and revision, and/or designee to audit care plans weekly fithe routine care planning schedule as well as admissions and readmissions to the facility in x.8 weeks to ensure facility staff review and Resident Centered Comprehensive Care Plancesidents in the facility. 4. Results of audits will be brought to month quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	lect d record e to care the etice. ce 7/2018 of Nursing are DON following s for new 5 x week revise the n of
	or as requested by the				

Facility ID: VAC159

PRINTED: 06/19/2018

MCTHON SHAREST CONTROL		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED B NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PA 42	E CONSTRUCTION	2. (2	DATE SURVEY COMPLETED
		495143	B WING			C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REP	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(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 CORR LEACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X ^E) COMPLETION DATE
F 657	team after each asse comprehensive and cassessments.	ssment, including both the	F 65	7		

The findings included:

1. The facility staff failed to review and revise the Comprehensive Resident Centered Care Plan for Resident #268 in regards to pain management and Advance Directive.

Based on staff interview, clinical record review and in the course of a complaint investigation, the

Comprehensive Resident Centered Care Plan for 5 of 45 residents in the survey sample (Resident

facility failed to review and revise the

#268, #82, #93, #49 and #26).

Resident #268 was readmitted to the facility on 1/19/16 with diagnoses of, but not limited to high blood pressure, Alzheimer's Disease, cancer to the left breast, low back pain and osteoarthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/1/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #268 was also coded as requiring supervision with set up help from the facility staff for dressing, personal hygiene and bathing. The resident expired in the facility on 6/26/17.

The surveyor performed a closed clinical record review on Resident #268 on 6/1 and 6/4/18. During this review, it was noted by the surveyor that the facility staff had received physician orders for the following dates:

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495143	B. WING		06/04/2018
NAME OF PI	ROVIDER OR SUPPLIFE			STREET ADDRESS, CITY STATE, ZIP CODE	
			2	1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	нав		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 657	Continued From pag	e 59	F 657		
W WESTAM	" 11/10/16 Do No		, 50,		
		nyl patch (used for pain) was			
		of 12 mcg/hr and then			
	increased to 25 mcg.				
	The surveyor review	ed the Comprehensive			
	State of the state	Care Plan and under "Pain			
	Management" there				
	~	9/15 with a revision date of			
	6/26/17. Under "Adv	ance Directive" on the care			
	plan, the date initiate 4/13/16 with a resolv	ed was documented for red date of 12/14/16.			
	MDS nurse #1 of the The MDS nurse #1 s	the surveyor notified the above documented findings. stated, "I see that I just care plan with the new			
	At 4:00 and the arm	augr potified the			
	At 4:00 pm, the surv administrative team findings.	of the above documented			
	No further information	on was provided to the			
		exit conference on 6/4/18.			
	This was a complain	t investigation deficiency			
ı	related to Resident #	‡268.			
		aff failed to review and review			
		Resident Centered Care Plan			
	for Resident #82 in r	regards to a hospitalization.			
		eadmitted to the facility on			
	4/28/18 with the follo	owing diagnoses of, but not			

limited to high blood pressure, UTI, Parkinson's disease, anxiety disorder, depression, Psychotic Disorder and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTR NG	RUCTION	C	(3) DATE SURVEY COMPLETED
		495143	B WING				C
NAME OF DE	ROVIDER OR SUPPLIER	495145	I B WING		DDRESS, CITY, STATE.	ZIR CODE	06/04/2018
NAME OF PA	ROVIDER OR SUFFEER			500000000000000000000000000000000000000	UCE STREET	Zii GOGE	
MARTINS	VILLE HEALTH AND RE	НАВ		1002001300211000000	SVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATI CIENCY)	(X5) COMPLETION E DATE
F 657	coded as having a B Mental Status) score of 15. Resident #82 totally dependent or bed mobility, transfer totally dependent or and personal hygier. The surveyor perfor #82's clinical record this review of the numbed that the reside bed resulting in being room and the lacera requiring 6 stitches. The surveyor also re Resident Centered focus of "At risk for a documented as being "Interventions" there with all revision date documented as 6/6/1 reflect a revision date and 13/9/18. Resident #82 was a 3/13/18 and readmin on 4/12/18 with a difference of the surveyor also reflect a revision date and 13/18 with a difference of the surveyor also reflect a revision date and the surveyor and the surveyor also reflect a revision date and 13/18 and readmin on 4/12/18 with a difference of the surveyor and the surveyor also reflect a revision date and the surveyor also results and the surveyor also results and the surveyor and the surveyor also results and the surveyor also results and the surveyor and the	2/1/18, the resident was BIMS (Brief Interview for e of 13 out of a possible score was also coded as being a 2 or more staff members for and bathing. Then being a 1 staff member for dressing he. In the serview on Resident on 5/31 and 6/1/18. During was notes, the surveyor ent had a fall from out of his had taken to the emergency ation above his left eye. This fall occurred on 3/9/18, eviewed the Comprehensive Care Plan and under the falls" the date initiated was and 6/6/17. Under ewere 10 interventions listed es for each intervention being 117. The care plan did not the that corresponded with the admitted to the hospital on tited back to the nursing facility agnosis of respiratory failure, not revised to include the	F	657			
·	(DON) and corporal documented finding The surveyor aske been initiated on the	ed the director of nursing te nurse of the above ps on 6/4/18 at 11:10 am. ed if a baseline care plan had e resident once he was the facility. The DON stated,					

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"Let me make a phone call and talk to MDS."

Event ID: 56XM11

Facility ID: VA0159

If continuation sheet Page 61 of 126



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495143	B. WING _		C 06/04/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010	
MARTINS	VILLE HEALTH AND RE	нав		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF COMPLETION
F 657	Continued From page	e 61	F6	57	
	baseline care plan wiresident had a compiplace." The surveyor the surveyor find the revithat occurred on 3/9/ when the resident rethospital. The DON ricare plan and then stoare plan was update she would expect he in each of the above and the DON replied.	as not done because the rehensive care plan in or asked if she could show on the care plan would the ision dates to reflect a fall 18 and the date of revision turned to the facility from the lead over the comprehensive tated, "I don't see where the lead." The surveyor asked if r staff to revise the care plan documented circumstances, "Yes".			
	the above documents pm.	ed findings on 6/4/18 at 4			
		n was provided to the exit conference on 6/4/18.			
	the Comprehensive for Resident #93 in re	aff failed to review and revise Resident Centered Care Plan egards to fluid restrictions. admitted to the facility on			

bathing.

9/2/15 with the following diagnoses of, but not limited to high blood pressure. diabetes, stroke, seizure disorder, anxiety disorder, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference date) of 5/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. Resident #93 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for

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		495143	B. WING	-	C 06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND REF	IAB		SPRUCE STREET TINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 657	Continued From page	e 62	F 657		
	#93's clinical record of During this review, the following entry made 13:43 (1:43 pm): " "1.5 L (liter) fluid 1020 cc from dietary and Resident continues to fluid restriction.	restriction daily every shift and 480 from nursing. be non-complaint with dent educated on the ng fluid restriction. Resident to with her at all times. ding but continues to be continue to encourage			
	The comprehensive care plan was also reviewed by the surveyor for fluid restrictions on Resident #93. The surveyor did not find documentation on the resident's care plan for the resident being non-complaint with the above documented fluid restrictions. The last revision date on the care plan for fluid restriction was 1/16/17.				
	ENGINEERS CHARLES CONTRACTOR CHARLES CONTRACTOR CONTRAC	the administrative team of ed findings on 5/31/18 at 4 room.			
	For Resident #26, review and revise the	exit conference on 6/4/18. the facility staff failed lo Residents CCP plan) when the Residents			

The record review revealed that Resident #26 had been admitted to the facility 09/28/15.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	NO 0000000 000000		ISTRUCTION	(X3) DATE SURVEY COMPLETED
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		495143	B. WiNG _			06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER	350 200 2530		STREE	T ADDRESS CITY STATE ZIP CODE	
MADTING	VILLE HEALTH AND REI	HAR		1607 S	SPRUCE STREET	
MAKIMO	VILLE REALIN AND KE	nao		MART	TINSVILLE, VA 24112	
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F 657	Continued From page	e 63	Ff	657		
	Diagnoses included,	but were not limited to,				
	peripheral vascular d kidney disease, and	fisease, asthma, chronic diabetes.				
	Section C (cognitive	patterns) of the Residents				
		status MDS (minimum data				
		n an ARD (assessment 8/14/18 included a BIMS				
		ental status) summary score				
		traints and alarms) had been				
	coded (0) to indicate rails.	the Resident did not use bed				
0	i diis.					
±8.	And the same of th	ximately 6:15 p.m., during an				
	3 N	ent #26 the Resident stated aken away her bedrails and				
		em to pull herself over and				
18 22		ent #26 stated they kept me				
10	from being scared.					
	On 05/31/18 at appro	oximately 8:08 a.m., Resident				
60 80		as a concern over her				
Ų.		ved and stated she also used				
	the floor.	cord on so it would not fall in				
	A review of the Resid	dents current CCP revealed				
		luded the interventions "per				
	rsd (resident) reques	st she prefers the call bell to				
		bed rail" and "Call bell within				
	reach-resident prefer around left bed rail."	rs to have call bell wrapped				
		d DON (director of nursing)				
		concerns regarding the lents siderails/bedrails on				
	05/31/18 at approxim					

The administrator was unable to provide an exact

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING			C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE	1 00/04/2018
					PRUCE STREET	
MARTINS	VILLE HEALTH AND REI	IAB			INSVILLE, VA 24112	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 657	Continued From page	e 64	F	657		
	200 at 20 at 100	ents side rails were removed		307		
	Appearance of the second secon	netime between January				
		n regarding this issue was y team prior to the exit				
	review and revise the	the facility staff failed to Residents CCP plan) in regards to contact				
	The Residents contact discontinued on 03/27	ANATHA DI PINA				
	had been admitted to Diagnoses included, t essential hypertensio	vealed that Resident #49 the facility 03/16/18. but were not limited to, n, gastroesophageal reflux rder, and major depressive				
	admission MDS (mini with an ARD (assess 03/23/18 included a E	patterns) of the Residents mum data set) assessment ment reference date) of BIMS (brief interview for ry) score of 10 out of a				
		ncluded the focus area "I am solation and not able to al OOR (out of room)				
	The clinical record included 03/27/18 to disc precautions.	cluded a physicians order continue contact				

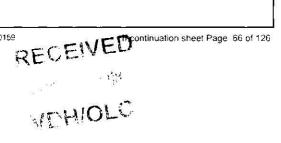
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CLIVILIA	STON WILDIOANE &	WILDICAID SERVICES		<u></u>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С .		
	899	495143	8 WING		06/04/2018		
NAME OF PE	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, 7IP CODE			
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	MEEE GEACITIAND NEI		N	ARTINSVILLE, VA 24112			
(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)			
F 657	Continued From page	e 65	F 657				
		imately 11:50 a.m., the MDS	1 551				
		d about the CCP and the					
	Residents isolation st	atus. The MDS coordinator					
		ew the CCP. After reviewing					
		ordinator verbalized to the					
	updated it.	P was incorrect and she had					
	The administrative staff were notified of the issue						
		nts CCP during a meeting					
	with the survey team approximately 2:50 p						
	approximately 2.50 p						
	No further information	n regarding the incorrect					
	CCP was provided to	the survey team prior to the					
	exit conference.						
		eet Professional Standards	F 658	1. Resident #268 has been discharged from	the 7/4/2018		
SS=E	CFR(s): 483.21(b)(3)	(1)		facility and has expired. 2. Residents that reside in the facility have t	he		
	§483.21(b)(3) Compr	ehensive Care Plans		potential to be effected by this deficient pra			
		d or arranged by the facility,		3. Nursing Staff re-educated on importance			
		mprehensive care plan,		medication times and signing off medicatio			
	must-			the time frame they are ordered on 6/4/2018 Learning Training regarding Medication	. Relias		
	(i) Meet professional	•		Administration completed by Nursing Staff	on or		
	by:	is not met as evidenced		by 6/22/2018. Audit of Medication Adminis			
		iew, clinical record review,		Medication Sign Offs to be completed by U			
		ew and during the course of		Managers and/or Designee 5 x week x 8 we			
		tion, the facility staff failed to		ensure facility staff follow professional stan practice when administering medication to t			
		andards of practice when		residents in the facility.			
		ation to 1 of 45 residents in		4. Results of audits will be brought to mont	hly:		
	the survey sample (Resident #268).			quarterly Quality Assurance Performance			
	The findings included);		Improvement (QAPI) Meeting for review as recommendations implemented as indicated			
	The facility staff failed	to follow professional					
	standards of nursing	practice when administering					
	medications to Resid	ent #268.					

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Event ID: 56XM11

Facility ID: VA0159



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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			ON	MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TIPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED	
						С	
		495143	B WING			06/04/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	17.77	
MADTINO				1607 SPRUCE STREET			
MARIINS	VILLE HEALTH AND R	EHAB		MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 658	Continued From page	ge 66		658			
1 000			F 3	000			
		readmitted to the facility on ses of, but not limited to high					
	The second secon	heimer's disease, cancer to					
	3	pack pain and osteoarthritis.					
		hange MDS (Minimum Data					
		Assessment Reference Date)					
		ent was coded as having a					
		w for Mental Status) score of					
	6 out of a possible s	score of 15. Resident #268					
	was also coded as i	requiring supervision with set					
	72 29	cility staff for dressing,					
		nd bathing. The resident					
	expired in the facilit	y on 6/26/17.					
The surveyor performed a closed clinical record review on Resident #268 on 6/1 and 6/4/18 pertaining to a complaint that was received in the Office of Licensure and Certification on 6/1/17. The complainant alleges the facility staff failed to administer pain medications to Resident #268 as prescribed by the physician.							
	On 5/31/18 at 1:00 i	pm. the surveyor requested					
		copy of Resident #268's MAR					
		stration Record) and Time					
	The second of the second of	tion administration for					
		March, April and May 2018					
	from the director of	nursing. The surveyor					
		orts and noted that the					
		ication that had scheduled					
		vas given 2-3 hours after					
		re varied among different					
	shifts and nurses the February, March, Ap	rough the months of January, oril and May.					
	ANGLOSTIC DE SE SEPRENCIA MAGNESANO, DESERGO, MIGOLA	am, the surveyor notified the					
		and, the surveyor notified the dasked if (name of					
	•	nistrated her pain medication					

in a timely manner. The corporate nurse stated,

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	(20)			OMB	NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A BUILDING			ATE SURVEY CMPLETED
		495143	B. WING				C 06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADD	DRESS CITY, STATE, ZIP CODE		
MADTING	/ILLE HEALTH AND REA	1A D		1607 SPRU	CE STREET		
WARTING	ALLE REALITIAND REP	IAD		MARTINS	VILLE, VA 24112		***
(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 CORR (FACH CORRECTIVE ACTION SH PROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET ON DATE
F 658	then we can discuss to nurse reviewed the all then stated, "According each of the pain med. Some of them were good scheduled time that the given to the resident." Corporate nurse what would hold her nursing administrating medical corporate nurse state and an hour after the surveyor requested a standard of practice with medications to the result of the surveyor in the direct provided the surveyor in the direct passed within one hour after the surveyor in the direct provided the surveyor in the direct provided the surveyor in the direct passed within one hour after the all the surveyor in the direct passed within one hour after the all the surveyor in the direct passed within one hour after the all the surveyor in the direct passed within one hour after the surveyor in the direct passed within one hour after the surveyor in the direct passed within one hour after the surveyor in the direct passed within one hour after the surveyor in the direct passed within one hour after the surveyor in the direct passed within	reports that you have and this further." The corporate bove requested reports and no to the time analysis for ications, they were not. iiven 2-3 hours after the ney were supposed to be. "The surveyor asked the was the standard that she ag staff accountable when attions to the residents. The d, "You have an hour before scheduled time." The copy of the facility's when administrating sidents.	F	658			
		the administrative team of ed findings on 6/4/18 at 4					
E 27F	*This is a complaint in related to Resident #.	exit conference on 6/4/18. nvestigation deficiency	=	675	RECE	W	
L 0/2	Quality of Life		F	013	115 141		

SS=E CFR(s): 483.24

PRINTED: 06/19/2018

	ID HOW IN OLIVIOLO			FORM APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES	24 1000	(24/14)	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	B WING		C 06/04/2018
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY STATE, ZIP CODE	1 00/04/2016
			07 SPRUCE STREET	
MARTINSVILLE HEALTH AND RE	HAB		ARTINSVILLE, VA 24112	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
Quality of life is a fun applies to all care an residents. Each residents. Each residents. Each residents. Each residents. Each residents provide the highest practicab psychosocial well-be resident's compreher of care. This REQUIREMENT by: Based on observation interview and clinical course of a complain determined the facility 45 residents (Reside physician ordered mere Failed to provide Resident by the physical course of a complain determined the facility 45 residents (Reside physician ordered mere Failed to provide Resident by the physical conductor of t	Section of the course of the course of a complaint investigation, it was determined the facility staff failed to provide 2 of 45 residents (Residents #86 and 118) with hissulin as ordered by the physician. Findings: 1. The facility staff failed to provide Residents #86 with insulin as ordered by the physician. Resident #86 was admitted to the facility on 8/17/18. His admission diagnoses included: Diabetes il, Anxiety, Complete amputation at knee level, bilateral, and anemia.		. Both resident #8 and #118's Physicians who tiffed that residents did not receive median a timely manner. No new orders noted. Provide that reside in the facility have notential to be effected by this deficient provide the second to be effected by this deficient provide the second to be effected by this deficient provide the second to be effected by this deficient provide the second to be provided to the second to be provided to be prov	cations the lectice. fuman DON and lected to be ling lecteds to per thly/ nd

dated 5/3/18 coded the resident with unimpaired communications skills. His cognitive ability showed slight memory impairment during testing. The same interview testing indicated the resident

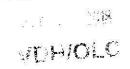
PRINTED: 06/19/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	50 AMERICAN SA	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING _	1722	C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
MARTINS	VILLE HEALTH AND REP	IAB		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 675	hopeless", had trouble energy. The MDS captured the during the look back produced indicators for psychosophysical, verbal or oth documented. The resergecting staff care event the MDS coded the mintervention of at least the ADLs (activities of was documented as a set-up help only. The both bowel and bladd intervention to provide the resident's CCP (a documented the resident produced, arguing with care, cursing staff, not line in the produced interventions including meds, attempting interventions, speaking in capture for pain, etc. The physician's order documented the insulf four times daily, per set to the accuchecks dophysician ordered the scale Novolog admining the produced in the scale in the s	relt "down, depressed or e sleeping, and had little e resident's behaviors period. The resident had no sis and no indicators for her behavior symptoms ident was documented as ery one to three days. resident as requiring the tone staff member for all fidaily living.) Resident #86 able to feed himself with resident was incontinent of er and required staff e care. recomprehensive care plan lent with behaviors (refusing the staff, calling 911, refusing the staff, calling staff and yelling). In groviding doctor-ordered reventions before behavior alm voice, diversion, check in Novolog be administered liding scale and according the at the same time. The accuchecks and the sliding stration to be done prior to	F 6	75	
scale Novolog administration to be done prior to meals and at the hour of sleep every day. (6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM.)					

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

On 5/29/18 at 6:10 PM Resident # 86 was interviewed. He complained to the surveyor that

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	4		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATF SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	- May 2 May
MARTINS	VILLE HEALTH AND REI	HAB		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 675	his insulin was being He said they'll come i (accucheck) and then up with my insulin. Resident #86 stated, is not the same by the the wrong dose." The they would come in a done and he didn't was The resident's MARS May 2018. The insulin recorded at the same nursing staff so it was accuchecks were take insulin was provided. On several occasions insulin was administe and not before as the 1. 4/2/18—11:00 AM do 2. 4/4/18—6:30 AM do 3. 4/5/186:30 AM do 4. 4/7/1811:30 dose 5. 4/8/186:30 dose (6. 4/10/186:30 dose (7. 4/10/1811:30 AM 8. 4/11/1811:30 AM	provided at the wrong times. In and get my blood sugar In 2-3 hours later they show "You know my blood sugar In—and they're giving me In—and they're giving me Ine—and they're giving me Inesident also complained It 5 AM to get his accucheck In to be waked up for that. In were reviewed for April and In and accuchecks were both It time on the computer by In not possible to prove the In several hours before the In the 6:30 AM/11:30 AM In red after breakfast or lunch In physician had ordered: In the 6:30 AM and In the get a	F 67		
	9. 4/13/1811:30 AM 10. 4/16/1811:30 AM 11. 4/19/1811:30 AM 12. 4/21/1811:30 AM 13. 5/4/1811:30 AM 14. 5/5/1811:30 AM 15. 5/6/1811:30 AM	M dose @1:13 PM M dose @ 1:30 PM. M dose @ 1:22 PM dose @1:53 PM dose@ 1:42 PM dose @1:33 PM			

17. 5/9/19--11:30 AM dose @ 1:18 PM 18. 5/10/18--11:30 AM dose@ 1:22 PM

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495143	B. WING	POS PE	C 06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER	 .	ST	REET ADDRESS: CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND REP	HAB	200	07 SPRUCE STREET ARTINSVILLE, VA 24112	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 675	delivered to his room PM during the onsite The 4/18/18/ 9:00 PM on 4/19/18 at 12:28 A On 4/28/18 and 4/29/	M dose@ 1:42 PM M dose@ 1:26 PM M dose @1:34 PM M dose @ 2:00 PM Inch was observed to be between 12:45 PM and 1:00 survey days. I insulin was administered IM. 18 the 6:30 AM insulin was AM both mornings—2 1/2	F 675		
	The administrator and these findings on 5/3	d DON were informed of 1/18 at 2:51 PM.			
	This was a complaint deficiency. 2.For Resident #118, the facility staff failed to administer the Residents physician ordered antibiotic augmentin as ordered. This medication was available in the stat box for administration.				
	had been admitted to Diagnoses included, dementia without beh	but were not limited to,			
	quarterly MDS (minin with an ARD (assess 04/27/18 had been of Resident had probler	patterns) of the Residents num data set) assessment ment reference date) of oded 1/1/3 to indicate the ns with long and short term verely impaired in cognitive n making.			

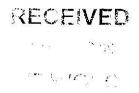
FORM CMS-2567(02-99) Previous Versions Obsolete

The Residents clinical record included a

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Facility ID: VA0159

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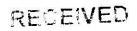
OLIVILIV	OT OIL MEDIOMILE A	MEDIONID SERVICES			CIVID 140, 0330-0331
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			-		c
		495143	B WING	1 1929	06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	k 	STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010
			160	07 SPRUCE STREET	
MARTINS	VILLE HEALTH AND RE	HAB	MA	ARTINSVILLE, VA 24112	
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	MANUFACTURE CONTRACTOR
F 675	Continued From page	e 72	F 675		
	physicians order (05/	24/18) for the antibiotic			
	augmentin 875-125 r	ng give 1 tablet via g-tube			
	two times a day-pner	umomia.			
	A review of the Resid	lents eMARs (electronic			
		ation records) revealed that			
		documented on 05/24/18 at			
	22:34 (10:34 p.m.) th	at the medication was not			
	available "awaiting in	from pharmacy."			
	The first dose was do administered on 05/2				
	A review of the stat be medication would have administration.	ox list indicated that this ve been available for			
	regarding the augme	aff were notified of the issue ntin during a meeting with 15/31/18 at approximately			
	No further information	n regarding this issue was		. Resident # 268 had discharged from the f	
		y team prior to the exit		and is now deceased. Resident #116 had po	
	conference.			lushed on 6/5/2018, no issues. MD aware orders. Resident #115's physician made aw	
F 684	Quality of Care		F 687	new orders noted.	arc, no
SS=E	CFR(s): 483.25		2	2. Residents that reside in the facility have to potential to be effected by this deficient pra	
	§ 483.25 Quality of c	are	0.50	3. Staff re-educated by DON and Human R	
	Quality of care is a fu	indamental principle that		egarding maintaining the highest practical	
		nt and care provided to		being of the residents in the facility. Physic	
		sed on the comprehensive		Sheet Audit to be completed by DON and/o	The same of the sa
		dent, the facility must ensure		Designee regarding medication administration	
		e treatment and care in		week x 8 weeks to ensure facility staff adm	inister
		essional standards of		nedications per Physician's order.	k lee
	care plan, and the re	hensive person-centered		 Results of audits will be brought to mont quarterly Quality Assurance Performance In 	
		T is not met as evidenced		QAPI) Meeting for review and recommend	
	HE GOTTEMEN			mplemented as indicated.	100 (100 (100 (100 (100 (100 (100 (100

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Event ID: 56XM11

Eacility ID: VA0159

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391				
	DEDEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0. 1000 0000 00000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					С			
		495143	B. WING	and the second s	06/04/2018			
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE				
MADTINE	VILLE HEALTH AND RE	HAR	11	507 SPRUCE STREET				
MAKING	VICEE HEACHT AND INC	. IAB	N	ARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION			
F 684	and in the course of facility staff failed to well-being for 3 of 45 sample (Resident # The findings include 1. The facility staff medication, Lortab, a physician for Resider Resident #268 was 1/19/16 with diagnos blood pressure, Alzh the left breast, low b On the significant ch Set) with an ARD (A of 5/1/17, the reside BIMS (Brief Interview 6 out of a possible s was also coded as rup help from the facility personal hygiene ar expired in the facility	view, clinical record review a complaint investigation, the maintain the highest practical 5 residents in the survey 268, #116 and #115). d: If failed to administer a pain as prescribed by the ent #268. readmitted to the facility on see of, but not limited to high neimer's disease, cancer to eack pain and osteoarthritis. Isange MDS (Minimum Data ssessment Reference Date) int was coded as having a w for Mental Status) score of core of 15. Resident #268 equiring supervision with set tility staff for dressing, and bathing. The resident	F 684					
TOTAL DESIGNATION OF THE PROPERTY OF THE PROPE	pertaining to a comp Office of Licensure a The complainant all administer pain med	#268 on 6/1 and 6/4/18 claint that was received in the end Certification on 6/1/17. eges the facility staff failed to dications to Resident #268 as enserted. It was noted that						
	Resident #268 was (milligram) 1 tablet bedtime. The physi	prescribed Lortab 7.5 /325mg by mouth after meals and at cian gave this order on 7, the physician increased the						

meals and at bedtime.

pain medication to 10 mg 1 tablet by mouth after

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	1000 100		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BJILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER			FREET ADDRESS CITY, STATE, ZIP CODE	1 00/04/2010
				507 SPRUCE STREET	
MARTINS	VILLE HEALTH AND R	EHAB	N	ARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From pa	ge 74	F 684		
	the "Time Analysis" January. February. The reports were renoted that the above were given 2-3 hou various shifts and be requested months. surveyor notified the (name of repain medication in a corporate nurse stareports that you have this further." The coabove requested re "According to the tippain medications, the were given 2-3 hou that they were suppresident." The surveyor what was the her nursing staff according to the tippain medications, the were given 2-3 hou that they were suppresident." The surveyor what was the her nursing staff according to the include the schedule of the schedule o	ested and received copies of reports for the months of March, April and May 2018. Eviewed and the surveyor reportered pain medications are after the ordered times on any various nurses for the above On 6/4/18 at 11:30 am, the reporter of corporate nurse and asked if resident) was administrated her at timely manner. The sted, "Let me look over the reports and then we can discuss corporate nurse reviewed the reports and then stated, are analysis for each of the responsible to be given to the responsible to the given to the responsible to the residents. The corporate have an hour before and an aduled time." The surveyor of the facility's standard of inistrating medications to the rector of nursing (DON)			
	"Preventing Medica Reference" which re passed within one h	or with a copy of titled attended atten			
		ided the surveyor with another			

Sixth Edition (2013) page 530, which read in part,

" ... Verify that the medication is being

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO A BUILDING		(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER		STR	EET ADDRESS CITY STATE ZIP CODE	
MARTINS	VILLE HEALTH AND REI	HAB		7 SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF COR (FACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 684	Continued From page administrated at the p		F 684		
	77 - 27	the administrative team of ed findings on 6/4/18 at 4			
		n was provided to the exit conference on 6/4/18.			
	*This is a complaint investigation deficiency related to Resident #268. 2. The facility staff failed to administer IV antibiotics as ordered by the physician for Resident # 115.				
	originally admitted to readmission date of 5 but were not limited to of urine, heart failure,	year-old- male who was the facility 4/6/99, with a 5/29/18. Diagnoses included o: urethral stricture, retention , vascular dementia without ce, and anxiety disorder.			
	Resident # 115 was r MDS (minimum data significant change as (assessment reference C of the MDS assess Section C1000, the fa Resident # 115's Cog impaired. Section H of bladder and bowel. In	if am, the clinical record for reviewed. The most recent set) assessment was a sessment with an ARD ce date) of 5/16/18. Section ses cognitive patterns. In acility staff documented that quitive status was severely of the MDS assesses in Section H0100, the facility at Resident # 115 had an			
		are for Resident # 115 was d on 5/23/18. A focus area for			

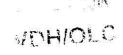
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Resident # 115 is documented as "Urinary Tract infection, potential or actual due to history of

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Facility ID: VA0159

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES		WES	OMB NO. (0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SU COMPLE	
		495143	B. WING_		C 06/04	/2018
MARTINSVILLE HEALTH AND REHAB SHIMMARY STATEMENT OF DESIGNATIONS SHIMMARY STATEMENT OF DESIGNATIONS STATEMENT OF DESIGNATIONS			50	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (FACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	chronic urinary tract catheter, bowel incomincuded but were not report signs and syminfection): Changes if or urine, dysuria, free On 5/30/18 at 10:02 the medication adminus # 115 and observed (gram) IV (intravenous surveyor observed "F	infections, use of supra pubic ntinence." Interventions t limited to: "Observe and ptoms of UTI (urinary tract n color, odor, or consistency	F 6	984		

On 5/30/18 at 10:15 am, the unit manager provided the surveyor with a handwritten nurses note for Resident # 115 that was written on 5/29/18 at 10:30 pm. Documentation stated "Resident very agitated medication given with some relief, called pharmacy concerning, antibiotic Cefepime, had to refax unable to get medication until tomorrow notified DON (director of nursing), she stated MD (medical doctor) was aware that medication will not be in until tomorrow." The surveyor spoke with the unit manager about the nurse's note and the fact that this is not an actual physician's order to hold the medication. Unit Manager agreed that there was

Cefepime for Resident # 115.

surveyor spoke with the unit manager and asked her what "H" meant. Unit manager stated that "H" meant hold. Unit manager stated that the medication was an IV medication and that the medication was not in the facility. The surveyor asked the unit manager the facility utilized a backup pharmacy. Unit manager stated "yes." The surveyor reviewed the clinical record further and could not locate an order to hold the

no order to hold the medication.

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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 C B WING 495143 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 77 F 684 On 5/31/18 at 3:40 pm, the administrative team was made aware of the findings as stated above. At this time, the DON also agreed that there was no actual order to hold the Cefepime for Resident # 115. No further information was provided to the survey team prior to the exit conference on 6/4/18. 3. The facility staff failed to ensure that the port a cath for Resident # 116 was routinely flushed and as a result, an order was written for Resident # 116 to consult with a vascular surgeon. Resident # 116 is a 63-year-old-male who was admitted to the facility on 4/10/13. Diagnoses included but were not limited to: schizophrenia, hypertension, major depressive disorder, and hypokalemia. The clinical record for Resident # 116 was reviewed on 5/30/18 at 11:00 am. The most

The clinical record for Resident # 116 was reviewed on 5/30/18 at 11:00 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/21/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff coded that Resident # 116 had a BIMS (brief interview for mental status) score of 5/15, which indicated that Resident # 116's cognitive status is severely impaired.

The current plan of care for Resident # 116 was reviewed and revised on 5/24/18. A focus area on the plan of care for Resident # 116 is documented as "Infection actual or at risk for related to: port-a cath-left chest." Interventions included but were not limited to: "Flush port-a-cath per order."

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	38			OMB NO	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUU A BUILD		STRUCTION	(X3) DATE S COMPS	
		405142	B WING			C	
NAME OF P	ROVIDER OR SUPPLIER	495143	B WING	STREE	T ADDRESS, CITY, STATE ZIP CODE	06/0	04/2018
					PRUCE STREET		
MARTINS	VILLE HEALTH AND RE	НАВ		MART	TINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH APPLICATION THE APPLICATION OF	OULD BE	COMP. ETION COATE
F 684	Continued From pag	e 78	F	684			
		gns and symptoms) of form MD (medical doctor)					
	Upon review of the c sheet for Resident # locate orders to flush On 5/30/18 at 11:24						
	the unit manager and	d asked if Resident # 116 had ort-a-cath flushed. Unit					
	documentation that i	lity policy for ssing an Implanted Port" has includes but is not limited to use it must be accessed, essed a minimum of once					
	was made aware of Upon being made av not having his port-a	m, the administrative team the findings as stated above. ware that Resident # 116 was -cath flushed, the DON ecause I was the one who					
		n, the surveyor requested g follow up on Resident #					
		n, the facility staff provided a following documentation.					
		ation administration record for showed that his port-a-cath November 16, 2017.					
	An order for Resider	nt # 116 was written on					

5/31/18 at 7:25 pm that stated "Heparin Lock

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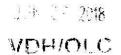
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DO PRODUCTOR PRODUCT AND DAY	E CONSTRUCTION ((X3) DATE S COMPL	
		495143 B. WING			C 06/04/2018	
	ROVIDER OR SUPPLIER	нав		0010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page Flush Solution 10 uni intravenously one time Port-A-Cath. If cath to accessed-flush with 2 flush with 5ml Hepariti." (Registered nurse) A telephone order for on 6/1/18 at 11:15 pm Surgeon regarding portions of the progress note was record for Resident #The progress note staport a cath using sterneedle, unable to accondified ordered to remessage with RP. (R. Transportation notified No further information team prior to the exited Free of Accident Haz CFR(s): 483.25(d)(1)	e 79 It/ml (milliliter) Use 5ml Ite a day every 30 day(s) for on left chest is not able to be 20 ml Normal Saline, then in (only to be done by RN) Resident # 116 was written in, to refer to Vascular port-a-cath." Idocumented in the clinical in 116 on 6/1/18 at 11:31 pm. ated, "Attempted to flush ille technique with Huber bess. Md (medical doctor) fer to vascular surgeon. Left responsible party) d." In was provided to the survey conference on 6/4/18. ards/Supervision/Devices (2)	F 684	DEFICIENCY)	sage of ent's ly sice. d/or s and	7/4/2018
	§483.25(d)(2)Each re supervision and assist accidents. This REQUIREMENT by: Based on, clinical re family interview, and	are that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent is not met as evidenced cord review, staff interview,		ADL assistance status, and removing any haza may be in resident's room. Unit Managers and/or Designee to audit to ens Kardex' are complete and accurate to reflect re transfer and ADL status 5 x a week x 8 weeks Department Heads to complete Care Keeper R 5 x a week x 8 weeks to ensure residents recei adequate supervision and assistance to prevent accidents. 4. Results of audits will be brought to monthly quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	sure esident's and Rounds ive t	

A

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		2900		O!	MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTI A BUILDIN	PLE CONSTRU	JCTION	íX	3) DATE SURVEY COMPLETED
		495143	B WING		0.7		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADD	DRESS, CITY STATE ZIP	CODE	5410-5381
MARTINS	VILLE HEALTH AND RE	HAB			CE STREET VILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG		PROVIDER'S PLAN O (FACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(Ab) COMPLETION DATE
F 689	sample received ade	Residents in the survey equate supervision and at accidents, Resident # 85, Resident # 101.	F 6	89			
	using the Hoyer Lift in the comprehensive promether wheelchair resident sustaining a lateral left leg which transferred to the em	d to transfer Resident # 85 as determined necessary by plan of care, during a transfer to the bed, resulting in the 14 inch laceration to the required that she be pergency room where she perrose drain, and required					
	of Licensure and Ce Office of Licensure a this facility reported which was investigat Medicare/Medicaid r	cident was sent into the Office ritification on 11/9/17. The and Certification converted incident into a complaint, and during an unannounced ecertification survey that took acility on 5/29/18 through					
	facility on 8/9/07 with 5/31/11. Diagnoses	riginally admitted to the name a readmission date of not moded but were not limited neart failure, hypertension,					
	reviewed on 5/31/18 MDS (minimum data quarterly assessmen	or Resident # 85 was at 9:35 am. The most recent set) assessment was a at with an ARD (assessment 2/18. Section C assesses					

cognitive patterns. In section C1000, the facility staff coded that Resident # 85's cognitive status



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ON	MB NO. 0938-0391		
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDE		STRUCTION	(X:	B) DATE SURVEY COMPLETED		
							С		
		495143	B. WING		All Mr.		06/04/2018		
NAME OF PR	ROVIDER OR SUPPLIER	***	387 5.7	STREET	TADDRESS CITY, STATE, ZIP CODE				
MADTINE	ALLE MEALTH AND DE	HAR		1607 SI	PRUCE STREET				
WARTING	/ILLE HEALTH AND RE	пав		MART	INSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BF	(X5) COMPLETION DATE		
F 689	Continued From pag	e 81	Fí	589					
		. Section G assesses	50133	300					
		Section G0110, the facility							
		it Resident # 85 totally							
		assistance of 2 or more							
	persons for transfers								
	The current plan of care for Resident #85 was								
		are for Resident #85 was d on 5/9/18. The focus area							
		lated to: Use of medication.							
	- 10	lity," has interventions that							
		t limited to "Transfer using							
	the Hoyer lift with sta	ff assistance."							
	On 5/31/18 at 9:42 a	m, the surveyor observed a							
		clinical record written on							
	S 977	The progress note stated,							
		h coworker was sitting at the							
	nurses station and he	eard someone calling out for							
		g down the hall observed							
		tremity bleeding with large							
	50.00	entimeter) gash. Skin flap							
	was intact and adipo	se tissue exposed. I skin flap, applied pressure,							
		nsport to ED (emergency							
		d patient leg while applying							
	pressure. Resident to	0 100 10 100							
	15	2:25 pm), resident RP							
	(responsible party) n	otified at 1432 (2:32 pm) of							
		ent was at ED. Will contact							
	ED for update on the	resident."							
	On 5/31/18 at 9:46 a	m, the surveyor observed a							
		clinical record written on							
		The progress note stated							
	"Returned from ER (emergency room) with orders							
		to leave in bed, left leg							
	wrapped in Coban w	ith Penrose drain in place,							

return to ER on Monday to remove drainage bag, and return in 2 weeks for suture removal, 1 gram

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A BUILDING		8 655-950 355-950 555-950 mmss
		495143	B WING		C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER	(American Confedition	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2018
			160	7 SPRUCE STREET	
MARTINSVILLE HEALTH AND REHAB		MA	RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIÊNC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 689	Continued From page	e 82	F 689		
	vancomycin given in		., .,		
		(milligram) BID (twice daily)			
	the DON (director of sustaining an injury to DON stated to the su (certified nursing assis	, the surveyor spoke with nursing) about Resident # 85 o her left leg on 11/4/17. The rveyor that the CNA stant) in this situation did ansferred the resident			
	LPN # 3(licensed pra of the survey team. T what happened durin which Resident # 85 leg. LPN # 3 stated th	the surveyor interviewed ctical nurse) in the presence he surveyor asked LPN # 3 g the incident on 11/4/17 in sustained an injury to her left nat she heard CNA calling for			
	there and "saw the ex stated that she put th pressure. The survey describe the wound t LPN #3 stated that the	other nurse rushed down ktent of the wound." LPN # 3 e skin back and applied for asked LPN # 3 to o Resident # 85's left leg. e wound was "Very long and eeded medical attention that I			
	couldn't give. LPN # at the physician and go ER. LPN # 3 stated the because she transfer LPN # 3 stated that the and pivot technique was and stated that Rewith standing during Resident # 85 stated	# stated that she contacted t Resident # 85 sent to the nat she educated the CNA red the resident improperly. ne CNA was using a stand when transferring Resident # esident # 85 was assisting			
	for the nurses.	errorrererere et et en			

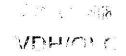
FORM CMS-2567(02-99) Previous Versions Obsolete

On 5/31/18 at 11:55 am, the surveyor interviewed CNA # 1 in the presence of the survey team. The

Event ID: 56XM11

Facility ID: VA0159

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
	3	495143	B. WING	to the latest	C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER	No Section Co.		RET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	/ILLE HEALTH AND F	REHAB	809000	7 SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIFS NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 689	11/4/17 when Resi her left leg. CNA # hurry because I wastand up and the lisomeone else was using stand and pir Resident # 85 "stocher on the bed she and saw the blood Resident # 85's leg nurse. CNA # 1 statime." CNA # 1 statime	A # 1 to tell what happened on dent # 85 sustained an injury to 1 stated "That day I was in a as behind." "I usually use the ft wasn't available." "I think using it." "I transferred her vot." CNA # 1 stated that od and did fine and when I sat a said oh my leg I looked down." CNA # 1 stated that she put gs on the bed and called for the ated. "I am assuming that she I that was on the bed at the ted that she had worked with the and was familiar with her new that she was supposed to 1 stated again that she was the reason she transferred 1 stated that she was placed if when she returned she was see of the lift with the residents. I pm, the surveyor reviewed the that was completed for to the incident on 11/4/17, ment was a quarterly in ARD of 10/4/17. In Section G aff documented that Resident appendent with transfers tance of two or more persons.	F 689		
		tion was provided to the survey xit conference on 6/4/18.			

*** This is a complaint deficiency***

2. The facility staff failed to maintain an accident

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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 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 689 Continued From page 84 F 689 free environment for Resident #82 in regards to a fall. Resident #82 was readmitted to the facility on 4/28/18 with the following diagnoses of, but not limited to high blood pressure. UTI, Parkinson's disease, anxiety disorder, depression, Psychotic Disorder and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #82 was also coded as being totally dependent on 2 or more staff members for bed mobility, transfer and bathing. Then being totally dependent on 1 staff member for dressing and personal hygiene. The surveyor performed a review on Resident #82's clinical record on 5/31 and 6/1/18. It was noted that the following documentation was made in the nurses' notes dated and timed for 3/9/18 at 1607 (4:07 pm): "Called to room by CNA. Upon entering room resident lying in floor on back, blood noted to head and floor. Approximately 2 in (inch) laceration noted to left eyebrow. Resident assessed. Pressure applied to laceration for approx. (approximately) 15 mins with bleeding controlled. Resident was not moved d/t (due to) fall with head injury ... Resident stated he was trying to hold on but is not used to not having side rails and could not hold on ...MD (medical doctor) notified new order to send to ER for evaluation ..." Then on 3/9/18 at 2334 (11:34 pm) the nurses' notes read in part " ... Resident returned to facility @ 9 pm via stretcher transported by EMS

accompanied by father ...Laceration to left eye with 6 stitches above eyebrow. L (left) eye

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	30 B	PLF CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
					c				
		495143	B. WING		06/04/2018				
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI					
				1607 SPRUCE STREET					
MARTINSVILLE HEALTH AND REHAB			MARTINSVILLE, VA 24112						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION (X5)				
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		ACTION SHOULD BE COMPLETION				
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED T DEFICIE					
- <u> </u>	<u> 19</u>								
E 690	C	- 05							
F 009	Continued From page		F6	89					
		Sm (small) bump on right							
		rasion to right knee. L (left)							
	"SANTE WINDS AND SELECTION OF THE PROPERTY OF	d purple. Ice pack applied							
	1,51	y upset that rails were							
		nd demanded that they be							
		r talked to father about new							
		s. Father stated he would							
	be talking to Administration"								
	The surveyor reviews	ed the MDS with ARD of							
	9.5%	esident was coded as being							
		2 or more staff members for							
	bed mobility, transfer								
	The comprehensive of	care plan was also reviewed							
	by the surveyor. Unde	er the "Focus" section of the							
	care plan it read in pa	art "Mobility impairment"							
	with the following inte	erventions listed on the care							
	plan:								
		nd reposition frequently.							
		: w/c (wheelchair)							
	Can ben within re								
	Encourage choic								
	mapect skill with	care. Report reddened							
		g or open areas to charge							
	nurse " Nail care PDN /a	as needed) -refer to the							
	Podiatrist PRN.	is needed) -relecto the							
		ort changes in physical							
	functioning ability	ort changes in physical							
	THE STATE OF THE PARTY OF THE P	ort changes in ROM (range							
	of motion) ability	or changes in row (range							
	" Praise effort at p	articipation							
	AND THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN	ed assistance w/ADL's							
	(activities of daily living								
	" Provide all needs								

w/toileting-provide incontinence care PRN.

Resident to have left hand orthotic placed in

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-30 4000		911094	OMB N	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		NSTRUCTION		TE SURVEY MPLETED
		495143	B. WING			(C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	_1	
				1607 5	SPRUCE STREET		
MARTINS	VILLE HEALTH AND REI	HAB		MAR	TINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIFS BY MUST BE PRECEDED BY FUIL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X6) COMPLETION DATE
F 689	Continued From page	9.86	C	689			
1 003	(i) (iii)		r.	009			
	Fig. spanie proposanie proposanie proposanie proposanie proposanie proposanie proposanie proposanie proposanie	t, and worn no more than 12					
	hours per order.	or "					
	" Therapy per orde	er.					
	The surveyor intervie	wed the director of nursing					
		:50 am in the conference					
		asked how the resident					
		above his left eyebrow on					
		ated, "He got the laceration					
		e of the bed when the CNA					
		he doctor was called and he					
	told us to send the re						
		veyor asked the DON if the					
		nt on the bed at the time of					
		ON stated, "No, they were					
	not." The surveyor a	sked the DON what was the					
	date that the side rail	ls were removed from the					
	resident's bed. The	DON stated, "I don't know					
	the exact date but I k	now we looked at the most					
	ambulatory residents	first and removed those first					
	and then we worked	our way through the rest of					
	the residents. I know	v we began this around the					
	29th of January and	ended taking the side rails					
	off the beds the midd	lle of March."					
	The surveyor intervie	ewed CNA #2 at 9:05 am in					
	THE RESIDENCE THE PROPERTY AND PROPERTY OF THE	. The surveyor asked CNA					
	#2 to tell the events i	eading up to and					
	surrounding	(name of resident) fall from					
	his bed on 3/9/18. C	NA #2 stated, "I was					
	changing him and us	ed the draw sheet to turn					
		dow which was away from the					
		was standing on. He began					
		could see him grabbing at the					
	0.50	ways." The surveyor asked					
		ils were on or off the bed at					
		CNA #2 stated, "I don't					
	remember when the	side rails were taken off but					

they were not on there when he fell out of the

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06/04/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIFE/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY COMPLETED

B. WING

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

495143

MARTINSVILLE HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
1607 SPRUCE STREET

MARTINSVILLE, VA 24112

(X4) ID SUMMARY ST PREFIX (EACH DEFICIENC TAG REGULATORY OR

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION;

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DA1E

F 689 Continued From page 87

bed." The surveyor asked CNA #2 how many staff members were needed to turn this resident and how would you know about this information to care for the resident. CNA #2 stated, "In the past he could use the side rails to hold on if he felt like he was falling. We did only use 1 aide to turn him but since the accident we are required to have 2. There is a kardex on each unit that tells you how many aides are needed to do certain things with the resident and then we also get a report from the charge nurse."

This surveyor and the team leader for the survey went into Resident #82's room at 9:25 am to interview the resident about the above documented fall on 3/9/18. The surveyors spoke to the resident but the resident was attempting to speak but the surveyors were unable to understand what he was saying. The father was sitting at the bedside of the resident and this surveyor asked if he could remember what the staff told him about the fall that occurred on 3/9/18. The father stated, "they took his side rails off the bed that morning and by that afternoon, the aide was in here changing him and he slid off the bed, hit his head on the table over there and had to get 6 stitches above his left eye. I don't understand why they took the side rails off the bed." The surveyor asked what exactly was he told regarding the removal of the side rails from the bed. The father stated, "They said it was against state law to have side rails on the bed."

The surveyor again interviewed the DON at 11:05 am in the conference room. The surveyor requested a copy of the bed rail assessments that were performed prior to the removal of the side rails from the bed. The DON stated, "I don't think that we have an assessment immediately prior to

F 689

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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 C 495143 B. WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 88 F 689 the removal of the side rails but I could be wrong. I have only been the DON here since about March and this was started prior to me accepting this position." At 1:38 pm, the surveyor interviewed LPN #2 by phone and asked if she could remember (name of resident) falling off the side of the bed on 3/9/18. LPN #2 stated, "The CNA called me to come into the resident's room and told me that she was changing him and he rolled off the side of the bed. I know she told me that she had been standing on the right side of the bed and turned him towards the window and that's when he fell." The surveyor asked if she could recall if there were side rails present on the bed at the time of the fall and she replied, "No". The surveyor asked how many aides are needed to turn the resident in bed. LPN #2 stated, "At that time we only used 1 aide but now after the fall we are required to have 2 staff in there so this does not happen again." The surveyor notified the administrative team on 6/4/18 at 4 pm of the above documented findings. The surveyor asked the administrative team if there was any other information that they would like for the survey team to consider in regards to the fall. The administrator stated, "I believe you have everything that we could give you at this point."

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the bedside table.

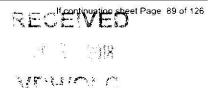
No further information was provided to the surveyor prior to the exit conference on 6/4/18.

3. The facility staff failed to maintain a hazard free environment for Resident #101 in regards to

Resident #101 was admitted to the facility on

Event ID: 56XM11

Facility ID: VA0159



PRINTED: 06/19/2018

DEPART	ND HUMAN SERVICES					FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	525000000 Ny15000000000000000000000000000000000000		NSTRUCTION	C	X3) DATE SURVEY COMPLETED
		495143	B. WING				C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	ā 30 š		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		3
MADTING	WILE HEALTH AND DE	HAR		1607	SPRUCE STREET		
MAKTINS	VILLE HEALTH AND RE	HAB		MAR	TINSVILLE, VA 24112		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION E DATE	
F 689	limited to anemia, co failure, high blood propisease, End Stage depression. On the limit an ARD (Assess 3/26/18, the resident BIMS (Brief Interview 15 out of a possible swas also coded as resoft 1 staff member for and being totally depfor bathing. On 5/30/18 at 3:30 p Resident #101's room interview, the survey table had worn edge resident stated, "It wwatching." The survey most the sharp edges that table. PN #2 and the resident's room and another one. That is sharp and you could wood is showing." Tanother bedside tabl room. LPN #2 statemaintenance directors.	ving diagnoses of, but not pronary artery disease, heart essure, Peripheral Vascular Renal Disease, diabetes and MDS (Minimum Data Set) sement Reference Date) of was coded as having a vior Mental Status) score of score of 15. Resident # 101 equiring extensive assistance or dressing, personal hygiene bendent on 2 staff members with the surveyor went into m. During the resident or observed the bedside is that had sharp edge. The will cut you if you are not eyor notified LPN #2 at 3:50 umented findings concerning the were present on the bedside is surveyor retuned to the stated, "I'll go and get is worn out and the edges are get a splinter because the life nurse went and found the and replaced the one in the did that she had notified the red bedside table in the resident's	F	689			
	The surveyor notified	d the administrative team of					

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the above documented findings on 5/31/18 at 4

surveyor prior to the exit conference on 6/4/18.

No further information was provided to the

Event ID: 56XM11

Facility ID: VA0159

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO). 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B WING	. 8		C 04/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 001	04/2010	
				1607 SPRUCE STREET			
MARTINS	VILLE HEALTH AND REF	IAB		MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE	
F 690 SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontiner §483.25(e)(1) The factor resident who is continuously admission receives a maintain continence is condition is or become	nce. cility must ensure that ment of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is	E.	690 1. Resident #115 had his eatheter secuphysician order on 5/30/2018. 2. Residents with urinary catheters ha potential to be effected by this deficie 3. Nursing staff re-educated in regards control, eatheter care, resident dignity and eatheter covers on 6/12/2018 and DON and Human Resources Director. Care Keeper Rounds Audit to be com Department Heads and/or Designee o	ve the outpractice, so to infection with catheters 6/13/2018 by the pleted by	7/4/2018	
	ensure that- (i) A resident who entindwelling catheter is resident's clinical concatheterization was noted (ii) A resident who enindwelling catheter or is assessed for remo as possible unless the demonstrates that caland	esident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an authorized unless one val of the catheter as soon e resident's clinical condition theterization is necessary;		catheters 5 x weekly x 8 weeks to ens receive appropriate treatment and servurinary tract infections. 4. Results of audits will be brought to quarterly Quality Assurance Performa Improvement (QAPI) Meeting for revrecommendations implemented as independent of the provention of the	ure residents vices to prevent monthly/ unce vicw and		
	receives appropriate prevent urinary tract continence to the ext §483.25(e)(3) For a rincontinence, based comprehensive asse ensure that a resider receives appropriate restore as much norrossible.	esident with fecal on the resident's ssment, the facility must at who is incontinent of bowel treatment and services to					

Based on observation, staff interview, clinical

by:

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES	100,000			OMB	NO. 0938-0391
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION		ATE SURVEY DMPLETED
		495143	B WING				C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		0.00.00
				1607 S	PRUCE STREET		
MAKTINS	VILLE HEALTH AND REI	HAB		MART	TINSVILLE, VA 24112		
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F 690	Continued From page	e 91	F	690			
	All of the second secon	cility document review, the		000			
		ensure that 1 out of 45					
	Residents in the surv						
	appropriate treatmen	t and services to prevent					
	urinary tract infection	s. Resident # 115.					
	The findings included	t :					
	The facility staff failed suprapubic catheter f secured.						
		originally admitted to the					
	The state of the s	readmission date of 5/29/18. out were not limited to:					
	20 Marie 17 Marie 20	ention of urine, heart failure,					
	vascular dementia wi						
	disturbance, and anx	iety disorder.					
	On 5/30/18 at the 9.5	1 am, the clinical record for					
		reviewed. The most recent					
	MDS (minimum data	set) assessment was a					
		sessment with an ARD					
	to the control of mile are made for the first of the first of the second	ce date) of 5/16/18. Section					
		ses cognitive patterns. In acility staff documented that					
		gnitive status was severely					
		of the MDS assesses					
	bladder and bowei. In	n Section H0100, the facility					
		it Resident # 115 had an					
	indwelling catheter.						
	The current plan of c	are for Resident # 115 was					
		d on 5/23/18. A focus area of					
		tion of bowel and bladder					
		el incontinence and D/T (due					
	to) use of a supra-pu	bic catheter-has Dx's					

(diagnoses) of urethral stricture & neurogenic bladder." Interventions included but were not

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	MENT OF TIERFILL	ID HOMAIN OLIVIOLO			FORM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES			2000	OMB NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1980 10 1000 1000 1000 1000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		C
NAME OF P	ROVIDER OR SUPPLIER	133143		REET ADDRESS, CITY, STATE, ZIP CODE	06/04/2018
			16	07 SPRUCE STREET	
MARTINSVILLE HEALTH AND REHAB		M	ARTINSVILLE, VA 24112		
(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 690	Continued From page	92	F 690		
. 000		atheter, avoid tugging on the	1 090		
		fer and delivery of care."			
		nor for placement Q (every)			
	shift and change PRI	N (as needed)."			
	Resident # 115 has o	current orders that were			
		an on 5/2/18 that included			
		"Catheter leg strap check			
		nent, dignity bag (fig leaf) r dignity." and "Suprapubic			
		shift and prn." (as needed)			
	facility staff providing surveyor observed a just above the pelvic	m, the surveyor observed the care to Resident # 115. The suprapubic catheter in place region of Resident # 115. eter was not secured at this			
		m. the surveyor observed the			
		care for Resident # 115. neter with 10ml (milliliter)			
	Block addition of the state of	he suprapubic catheter is not			
		am, the surveyor observed			
	The same of the sa	g with the unit manager. The rveyor observed Resident #			
		theter with a 10 ml bulb in			
		ager and the surveyor			
	observed that the su				
		not secured at this time. The that the catheter should be			
	The facility standard	of practice has			

documentation that includes but is not limited to: "Tape the catheter to the patient's abdomen or thigh to prevent pressure on the urethra at the

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	- 10		OMB NO. 0938-0391
	PEDEFICIENCIES CORRECTION	(X1) PROVIDER:SUPPLIER:CLIA IDENTIFICATION NUMBER.	1996 CONTROL OF THE STATE OF TH	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495143	B WING_		C 06/04/2018
NAME OF PF	ROVIDER OR SUPPLIER		11/5/—4 11/	STREET ADDRESS CITY, STATE, ZIP CODE	W1000
MARTING	/ILLE HEALTH AND REF	1AR		1607 SPRUCE STREET	
IIIAK I III O	NEEL HEALTH AND REI			MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE COMPLETION
F 690			F 6	90	
	No further information	regarding this issue was y team prior to the exit	F€	198 1. Residents #101 and #87's MD notific Communication forms updated. No ne	w orders.
	require dialysis receive with professional star comprehensive personal star comprehens	is not met as evidenced iew, clinical record review review, the facility staff are with the dialysis center in the survey sample (87). iff failed to coordinate care are in regards to incomplete		 Residents currently receiving dialysis potential to be effected by this deficient 3. Nursing staff re-educated on the imprompletion of the dialysis communicating for both pre-dialysis and post-dialysis be Designee. Administrator spoke with Fa Administrator over Davita Dialysis Cer 6/4/2018. Dialysis Communication Form Audit to by Unit Manager and/or Designee to en Communication Forms are completed 5 weeks to ensure the facility staff coording the dialysis center. Results of audits will be brought to a Quality Assurance Performance Improve (QAPI) Meeting for review and recomminglemented as indicated. 	practice. ortance of on form y DON and/or cility iter on be completed sure ESRD ix a week x 8 nate care with conthly/quarterly cement
	3/1/18 with the follow limited to anemia, confailure, high blood pre	dmitted to the facility on ing diagnoses of, but not ronary artery disease, heart essure, Peripheral Vascular Renal Disease, diabetes and		RECEIV	ED

depression. On the MDS (Minimum Data Set)

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		<u> </u>	OMB_NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MUL A. BUHLDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	ilionii .		STREET ADDRESS, CITY, STATE, ZIP COL	
MADTING	VILLE HEALTH AND RE	MAR		1607 SPRUCE STREET	
MAKING	VICEE HEALTH AND RE	nab		MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE COMPLETION DATE
F 698	Continued From pag-	e 94	F	698	
	50 CO	ment Reference Date) of	• :		
	The contract of the contract o	was coded as having a			
		for Mental Status) score of			
	The second secon	score of 15. Resident # 101			
		equiring extensive assistance			
		dressing, personal hygiene			
	for bathing.	endent on 2 staff members			
	The curreyer perform	ned a review of Resident			
	27	on 5/30 and 5/31/18.			
		e surveyor noted that either			
		documentation was missing			
		munication Record" for the			
	following dates: 3/8/				
		9/18, 4/7/18, 4/10/18, 7/18, 4/19/18, 4/21/18,			
		8/18, 5/3/18, 5/8/18, 5/10/18.			
	5/12/18, 5/15/18, 5/1				
	5/24/185/26/18 and 5	5/29/18.			
		n, the surveyor requested			
	To the Language of the Association College and College College College (Association College)	copy of the dialysis contract.			
		part " FACILITY will send			
		nentation as to how the ng managedProvider will			
		CILITY complete and			
	M S	ntation of each service			
	received by FACILIT	Y resident(s) as well as any			
	reaction to a service	received"			
	7.0	the administrative team on			
	6/4/18 at 4 pm the at	pove documented findings.			
		n was provided to the			
		exit conference on 6/4/18.			
	(55)	ailed to ensure that dialysis ts were completed for			
	- communication shee	ts were completed for			

Resident # 87.
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 56XM11

Facility ID: VA0159

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938-03					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495143	B. WING		C 06/04/2018			
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS CITY, STATE, ZIP CODE	3.5 1.00			
MARTINS	VILLE HEALTH AND REI	НАВ	55 065656	7 SPRUCE STREET RTINSVILLE, VA 24112				
(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 APPROPRIED DEFICIENCY)	BE COMPLETION			
F 698	Continued From page	95	F 698					
	originally admitted to readmission date of 4 but were not limited to disease), type 2 diable dementia without behappertension, and an The clinical record for reviewed on 5/30/18 MDS (minimum data Resident # 87 was a ARD (assessment resection C assesses C C0500, the facility start #87 has a BIMS (bries score of 9/15, which impairment. Section C treatments procedure CO100, the facility start Resident # 87 has has a BIMS (Bries score of 9/15, which impairments procedure CO100, the facility start Resident # 87 has has a BIMS (Bries score of 9/15).	xiety disorder. r Resident # 87 was at 2:16 pm. The most recent set) assessment for 30-day assessment with an ference date) of 5/3/18. cognitive patterns. In Section aff documented that Resident if interview for mental status) ndicates moderate cognitive D assesses special as and programs. In Section aff documented that d dialysis treatments while a						
	focus area "Alteration (related to) DX (diagr renal disease), receiv Interventions include "Observe for post-dia mental status, excess treatments, nausea," headache, severe leg The physician signed Resident # 87 on 5/2	are for Resident # 87 lists a in kidney function R/T mosis) of ESRD (end stage ving hemodialysis." If the current orders for the stage vince weight gain between vomiting, weakness, gramps."		RECEIV				

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<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES	100			OM	IB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3)) DATE SURVEY COMPLETED
							С
- 100000		495143	B WING	1272			06/04/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
MADTIMO	WILLE DEALTH AND DE	HAR		1607 SP	RUCE STREET		
MAKIINS	VILLE HEALTH AND RE	IAD		MARTIN	NSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET ON DATE
F 698		Dialysis Communication	F6	398			
	observed incomplete the following dates:	of May 2018, the surveyor communication records for 8, 5/15/18, 5/17/18, 5/19/18,					
	and 5/21/18.						
There was no "Dialysis Communication Record" in the clinical Record for Resident # 87 for the following dates: 5/3/18, 5/5/18, 5/12/18, 5/22/18, 5/24/18, 5/26/18,							
	5/29/18, and 5/31/18.						
	Hemodialysis" the "P" "1. A communication facility for any resider for hemodialysis. (ple	ity policy on "Coordination of rocedure" is documented as: format will be initiated by the nt going to an ESRD facility ease note that the ESRD ic due to the needs of the nic)					
	Nursing will collect resident to send to th	information regarding the e ESRD facility with the					
	resident-information r to:	recommended but not limited					1
		mation -face sheet					
	b. Copy of currer	nt physician orders					
	c. Copy of plan of						
	 d. Blank progres 						
		communication form					
		he resident information with					
		esignated appointments at					
	the ESRD facility. Nu						
		ents physical, mental, and					
		oral intake, activity tolerance					
	and change in physic	ian orders since last					
	appointment. 4. The ESRD facility is	is to review and complete					

the ESRD communication form at each visit.

5. Upon the resident's return to the facility,

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		3 Materials	С	
NAME OF P	ROVIDER OR SUPPLIER	400140		STREET ADDRESS ON STATE TO SOME		/04/2018	
MARTINS	VILLE HEALTH AND R	EHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	8		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICION CORRECTION CORREC	SHOULD BE	(X5) COMPLETION DATE	
F 698	Continued From page	ge 97	, F {	598		i 2	
	nursing wilf review to form and communic physician and other needed. 6. The facility will no scheduled resident a communication form. On 5/31/18 at 3:40 p was made aware of The administrator st contact with the dialifacility was not retur forms. The administration that the facility their portion of the communication of the communication.	ne ESRD communication ate with the resident's ancillary departments as tify the ESRD facility of care conferences through					
F 756 SS=D	provided to the survice conference on 6/4/16 Drug Regimen Revie CFR(s): 483.45(c)(1) §483.45(c) Drug Reg§483.45(c)(1) The dimust be reviewed at licensed pharmacist. §483.45(c)(2) This region of the resident's mediatives and these reports mediatives including the survival of the regularities including the survival of the survival o	ew, Report Irregular, Act On 10(2)(4)(5) gimen Review. fug regimen of each resident least once a month by a sview must include a review lical chart. marmacist must report any ttending physician and the ctor and director of nursing,	F 7	56 1. Medical Director reviewed and si recommendations on residents #22, 2. Residents that reside in the facilit potential to be effected by this defic 3. Medical Director and DON re-eduand signing pharmacy recommendation Audit to by Director of Nursing and/or design x 6 months to ensure the Medical Direction of Audits will be brought to Quality Assurance Performance Imp (QAPI) Meeting for review and recomplemented as indicated.	#49, and #82. y have the ient practice, ucated on reviewir tions each month, to be completed nee to monthly irector has ons, to monthly/quarter provement		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	IX2; MULT A BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		N 10	C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE.	
MARTINSVILLE HEALTH AND REHAB				PRUCE STREET INSVILLE, VA 24112		
(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 APPROPE DEFICIENCY)	BE COMPLETION
F 756	Continued From page	e 98	F 7	7 56		
	(d) of this section for	an unnecessary drug.				
	18 N . N	noted by the pharmacist				
	separate, written repo	ist be documented on a ort that is sent to the				
	Province and in terms with a first province of the control of the first of the control of the co	nd the facility's medical				
		of nursing and lists, at a				
		nt's name, the relevant drug, ne pharmacist identified.				
		ysician must document in the				
		cord that the identified				
	<u> </u>	reviewed and what, if any, n to address it. If there is to				
		medication, the attending				
	62	ument his or her rationale in				
	§483.45(c)(5) The fac	cility must develop and				
		procedures for the monthly				
		that include, but are not s for the different steps in				
		s the pharmacist must take				
		ifies an irregularity that				
	70	n to protect the resident. Lis not met as evidenced				
	by:	is not met as evidenced				
	Based on staff interv	riew and clinical record				
	The state of the s	aff failed to ensure the				
	medical director review	ewed pharmacy three of 45 Residents,				
	Residents #22, #49,					
	The findings included	i .				
		the facility failed to provide				
l		dical director had reviewed a addation dated 02/27/18.				

The record review revealed that Resident #22 had been admitted to the facility 06/30/17.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X3) DATE SURVEY COMPLETED		
		495143	B. WING		C 06/04/2018		
	ROVIDER OR SUPPLIER VILLE HEALTH AND REF	НАВ	16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112	1 33.04.2010		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION		
F 756	syndrome, cardiac ar dysphagia, and acute hypoxia. Section B (hearing/sp. Residents quarterly Massessment with an Adate) of 03/14/18 was Residents was in a pediscernible conscious. The clinical record increcommendation date physician had signed 02/28/18. The facility was unabout the surveyor that the reviewed the recommendation of the surveyor director of nursing) a verbalized to the surveyor ballized to the surveyor that the surveyor that the reviewed the recommendation of the surveyor that the reviewed the reviewed the recommendation of the surveyor that the reviewed	but were not limited to, down rest, anxiety disorder, respiratory failure with respiratory failure and respiratory failure with respirator	F 756				
	regarding the pharma	aff were notified of the issue acy recommendation during ervey team on 05/31/18 at .m.					
		n regarding this issue was y team prior to the exit					

2. For Resident #49, the facility failed to provide

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/0 (12010
MARTINS	VILLE HEALTH AND REP	HAB		7 SPRUCE STREET RTINSVILLE, VA 24112	
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 756	pharmacy recommental pharmacy recommental transfer in the record review review had been admitted to Diagnoses included, lessential hypertension disease, anxiety disordisorder. Section C (cognitive padmission MDS (minimited with an ARD (assession 3/23/18 included a Emental status summated possible 15 points.	dical director had reviewed a dation dated 03/19/18. vealed that Resident #49	F 756		
	physician had signed this recommendation on 03/20/18. The facility was unable to provide any evidence to the surveyor that the medical director had reviewed the recommendation. On 05/30/18 at approximately 9:00 a.m., the DON				
	that it had to be review The DON stated she	eyor that they were unaware wed by the medical director.			
	regarding the pharma	aff were notified of the issue cy recommendation during rvey team on 05/31/18 at			

approximately 2:50 p.m.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	12		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	9895	495143	B WING		C 06/04/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARTINS	VILLE HEALTH AND REP	I AB	100	607 SPRUCE STREET MARTINSVILLE, VA 24112		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
F 756	provided to the surve conference. 3. The facility staff fa nursing and the Medimonthly drug regimer Resident #82. Resident #82 was read/28/18 with the follow limited to high blood provided disease, anxiety disordisease, anxiety disordisease	regarding this issue was y team prior to the exit iled to ensure the director of cal Director signed the neview 4/27/18 for admitted to the facility on wing diagnoses of, but not pressure, UTI, Parkinson's reder, depression, Psychotic phrenia. On the annual MDS with an ARD (Assessment MT/18, the resident was MS (Brief Interview for of 13 out of a possible score was also coded as being 2 or more staff members for and bathing. Then being 1 staff member for dressing with an 6/1/18. During yor noted on the monthly dated 4/27/18 was not of nursing or by the Medical by review was noted to have a pharmacist had questioned	F 756			
	director of nursing of findings. The director	e surveyor notified the the above documented r of nursing stated, "I didn't n these along with the		RE	CEIVED	

Medical Doctor."

The surveyor notified the administrative team of

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CENIEN	STON MEDICANE &	MEDICAID SEIVICES	232 3	1/1987)	OND NO. 0936-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B. WING		C 06/04/2019		
NAME OF D	DOVERD OF CURRILIER	1	2	TREET ARRESCO, CITY, CTATE, TIR CONC.	06/04/2018		
NAME OF PE	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARTINS	VILLE HEALTH AND REI	HAB		607 SPRUCE STREET			
			N	MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(FACH 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 756	Continued From page	e 102	F 756				
		ed findings on 6/4/18 at 4 pm	i. tomar				
	in the conference roo						
	in the converence roo	(11).					
	No further information	n was provided to the					
		exit conference on 6/4/18.					
F 758		rchotropic Meds/PRN Use	F 758	1. Behavior monitoring re-initiated on 5/31/	2018 7/4/2018		
	CFR(s): 483.45(c)(3)			for resident #115. Resident #10's PRN Ativ			
33-0	Or 11(0). 100:10(0)(0)	(0)(1) (0)		discontinued on 5/31/2018.			
	§483.45(e) Psychotro	opic Drugs.		2. Residents receiving psychotropic medica	tions		
		hotropic drug is any drug that		have the potential to be effected by this defi	cient		
		s associated with mental		practice.			
	processes and behav	vior. These drugs include,		3. Nursing Department re-educated on PRN			
	but are not limited to,	drugs in the following	Psychotropic Medication use and completed on 6/22/2018. DON and Social Service Director to				
	categories:			review residents receiving psychotropic me			
	(i) Anti-psychotic;			weekly in Committee Meeting to review for			
	(ii) Anti-depressant;			appropriate behaviors, interventions, and gr			
	(iii) Anti-anxiety; and			dose reductions. Behavior Audit to be cond			
	(iv) Hypnotic			Director of Nursing and/or designee 5 x a w			
		6 64		weeks to ensure residents are free from unn			
	2950 NO	ensive assessment of a		medications.			
	resident, the facility n	nust ensure that		4. Results of audits will be brought to mont	hly'		
	C400 45/ \/4\ D			quarterly Quality Assurance Performance			
	And the second of the second s	ents who have not used		Improvement (QAPI) Meeting for review a			
		re not given these drugs		recommendations implemented as indicated	Į.		
		n is necessary to treat a diagnosed and documented					
		9					
	in the clinical record;						
	8483 45/eV/2\ Pecide	ents who use psychotropic					
	The state of the s	al dose reductions, and					
	behavioral intervention						
		effort to discontinue these					
	drugs;						
	§483.45(e)(3) Reside	ents do not receive					
		ursuant to a PRN order					
	100 100 10 100 100 100 100 100 100 100	on is necessary to treat a					
		ondition that is documented					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			AO	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	4	LE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495143	B WING	1000000-1000000 (1)		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
MARTINSVILLE HEALTH AND REHAB				1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREFIX TAG	(FACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION É ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 758	Continued From page	÷ 103	F 75	8		
İ	in the clinical record;	and				
	are limited to 14 days §483.45(e)(5), if the apprescribing practition appropriate for the Pf beyond 14 days, he crationale in the reside indicate the duration §483.45(e)(5) PRN o	er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order.				
	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced					
	review, the facility sta 45 Residents in the fi	riew and clinical record off failed to ensure that 2 of nal survey sample was free edications, Resident # 115				
	The findings included	l :				
	1. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Seroquel for Resident # 115.					
	facility 4/6/99, with a Diagnoses included	originally admitted to the readmission date of 5/29/18. out were not limited to: ention of urine, heart failure,				

Facility ID: VA0159

vascular dementia without behavioral disturbance, and anxiety disorder.

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CENTERS	OR MEDICARE &	MEDICAID SERVICES			ON	1B NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1), PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 06/04/2018
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			2	STREET ADDRESS, CITY, STATE, A 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE (IENCY)	(X5) COMPLETION DATE
	ontinued From page		F	758		

On 5/30/18 at the 9:51 am, the clinical record for Resident # 115 was reviewed. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 5/16/18. Section B of the MDS assesses hearing, speech, and vision. In Section B0700, Resident # 115 was assessed for the" ability to express ideas and wants, consider both verbal and nonverbal expression." The facility staff documented that Resident # 115 is "rarely/never understood." Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's Cognitive status was severely impaired. Section N of the MDS assesses medications. Section G of the MDS assesses functional status. In Section G0400, functional limitation in range of motion is assessed. The facility staff documented that Resident # 115 has bilateral impairment of the upper and lower extremities. In Section N0410, the facility staff documented that Resident # 115 received antipsychotic medications during the last 7 days since the ARD date.

The current plan of care for Resident # 115 was reviewed and revised on 5/23/18. A focus area documented on the plan of care is documented as "Potential for drug related complications associated with use of psychotropic medications related to: Antianxiety medication." Interventions included but were not limited to "Observe for target behaviors/symptoms of increased agitation, continuous yelling, pulling on peg tube and document," and "Provide non pharmaceutical interventions of repositioning, quiet environment to decrease target behaviors, anxiety, or depression.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING B WING STREET ADDRESS. CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB (X3) DATE SURVEY COMPLETED C 06/04/2018 STREET ADDRESS. CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 758 Continued From page 105 Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate	CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) NEED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 105 Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate	하지 않는 10 전에 가는 10 전에 되었다 "FUTEN (1977) THE TREET FOR			•		(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB STREET ADDRESS. CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 105 Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate						С
MARTINSVILLE HEALTH AND REHAB 1607 SPRUCE STREET MARTINSVILLE, VA 24112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 105 F 758			495143	B WING	2 <u></u>	06/04/2018
MARTINSVILLE, VA 24112 IX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 105 Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate	NAME OF PR	ROVIDER OR SUPPLIER		V 27	STREET ADDRESS, CITY, STATE, ZIP CO	DDE
F 758 Continued From page 105 Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record, nurse's notes, and progress notes, this surveyor could not locate	MARTINSVILLE HEALTH AND REHAB					
Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
monitoring of target behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Seroquel. On 5/30/18 at 11:45 am, the surveyor spoke with the unit manager about the target behaviors for Resident # 115. The surveyor asked the unit manager what target behaviors are displayed by Resident # 115. Unit manager responds, "He (Resident # 115) has these jerking movements. The surveyor asked unit manager if the jerking movements could be associated with the seizure disorder that Resident # 115 is also being medicated for. Unit manager stated "Yes." The surveyor asked the unit manager what behaviors were being managed with the use of the Seroquel. Unit manager did not provide an answer to the surveyor. The surveyor reviewed the medication administration record along with the unit manager. The unit manager agreed that appropriate target behaviors had not been identified and that there was no monitoring for side effects or effectiveness, nor were there non-pharmacological interventions listed associated with the use of Seroquel for Resident # 115. On 6/4/18 at 10:32 am, RN (registered nurse) # 1	F 758	Resident # 115 has a Tablet Give 25 mg virelated to other psych substance or known was initiated on 5/1/1 clinical record including administration record progress notes, this is monitoring of target the medication, side effer non-pharmacological associated with the LUC On 5/30/18 at 11:45 the unit manager about the unit manager about Resident # 115. The manager what target Resident # 115. Unit (Resident # 115) has The surveyor asked the surveyor asked the unit manager to the surveyor the medicated for. Unit managers to the surveyor the medication admirts the unit manager. The appropriate target be identified and that the side effects or effection-pharmacological associated with the LUC # 115.	a current order for "Seroquel a G-Tube one time a day notic disorder not due to a physiological condition" that 8. Upon further review of the ng the medication I, nurse's notes, and surveyor could not locate behaviors, effectiveness of cts, or documentation of interventions utilized use of Seroquel. am, the surveyor spoke with bout the target behaviors for surveyor asked the unit behaviors are displayed by manager responds, "He these jerking movements. Unit manager if the jerking associated with the seizure associated with the seizure of the nit manager stated "Yes." The nit manager stated "Yes." The nit manager what behaviors with the use of the ger did not provide an or. The surveyor reviewed histration record along with the unit manager agreed that haviors had not been are was no monitoring for eveness, nor were there interventions listed use of Seroquel for Resident	F	758	

MDS coordinator reviewed the plan of care along with the surveyor to identify target behaviors

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
					C		
		495143	B. WING		06/04/2018		
NAME OF PE	ROVIDER OR SUPPLIER	1.00		STREET ADDRESS, CITY, STATE, ZIP COI	DE		
MADTING	/II I E UEAI TU AND DEI	1AB		1607 SPRUCE STREET			
MARTINSVILLE HEALTH AND REHAB			MARTINSVILLE, VA 24112				
(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 X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 758	of Seroquel. RN # 1 of specific target behavior that." On 6/4/18 at 4:15 pm was made aware of the survey conference on 6/4/18 at 2. The facility staff fanceded) order for Attacked and the survey conference on 6/4/18 and the survey for the facility staff fanceded) order for Attacked the survey of the survey or perform the survey or perfor	In the administrative team ne findings as stated above. In regarding this issue was by team prior to the exit wan after 14 days for sician's Desk Reference, ypnotic medication used for ety. In the administrative team ne findings as stated above. In regarding this issue was by team prior to the exit was a prior to	F	758			
	No. 10 10	ded for anxiety. This order					
	was uated Z/0/T0.						

The surveyor notified the administrative team of the above documented findings on 5/31/18 at 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 06/04/2018
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET MARTINSVILLE, VA 24112	06/04/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATFMENT 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 APPROPRIA DEFICIENCY)	
F 758	order dated for 5/31/1 stated, "Contacted Dr this time. New order PRN"	g provided a telephone 8 at 1854 (6:54 pm) which (name of doctor) at noted to discontinue Ativan	F 758		
	No further information was provided to the surveyor prior to the exit conference on 6/4/18. 9 Free of Medication Error Rts 5 Pront or More		F 759	1. Resident #60's MD notified of improper administration of medication with no new o 2. Residents that reside in the facility have t potential to be effected by this deficient pract 3. Nursing staff completed a Relias Learning Course on Medication Administration- Avo Common Med Errors. Nursing Staff re-edu DON and Human Resources Director regard Medication Errors 6/12/2018 and 6/13/2018 Unit Manager and/or Designee will perform medication pass audits with staff charge nur 5 x week for 8 weeks to ensure ensure a meerror rate of less than 5%. 4. Results of audits will be brought to month Quality Assurance Performance Improveme (QAPI) Meeting for review and recommend implemented as indicated.	he ctice. g iding cated by ding ses dication hly/quarterly

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	5000 000	-3	C 06/04/2018
NAME OF PE	ROVIDER OR SUPPLIER				ET ADDRESS CITY STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND REP	HAB			SPRUCE STREET TINSVILLE, VA 24112	
(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 CORRECT (FACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 759	dry eye syndrome, chhyperlipidemia. The most recent MDS Resident # 60 was a an ARD (assessment Section C assesses of C0500, the facility sta # 60 has a BIMS (briestatus) score of 15/15 Resident # 60 is cogn. The physician signed Resident # 60 on 5/20 were not limited to: "C Solution 20-100 MCG times a day related to infection," and "Flona MCG/ACT 1 spray in for sinus relief." On 5/30/18 at 8:40 and medication pass with nurse) #2. During the administered the Con Resident # 60. LPN # # 60 with water or instafter use. LPN # 2 the Flonase Suspension did not instruct Resident Residen	structive pulmonary disease, aronic pain, and S (minimum data set) for quarterly assessment with reference date) of 4/17/18. cognitive patterns. In Section aff documented that Resident of interview for mental which indicated that nitively intact. The current orders for 8/18. Orders included but Combivent Respimat Aerosol GACT 1 inhalation orally four or acute upper respiratory	F	759		
		nstructions for Flonase that included but is not				

Here's how. in five easy steps.

"For best results, it's important to get a full dose.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	Viii Viii		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE (A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 06/04/2018	
NAME OF PE	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
MARTINS\	VILLE HEALTH AND RE	HAB	1000990	ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 759	Continued From page	e 109	F 759			
	0 651	hake spray bottle. Remove				
	translucent cap.	y from face. Pump until mist				
	Prime- Aim awagappears.	y nominace. Fump uniii mist				
		e gently to clear nostrils.				
	 Aim- Close one nozzle in other nostri 	nostril and put tip of spray				
		ray- While sniffing gently.				
	press down on spray	nozzle once or twice				
		instructions). You'll feel a				
	mouth."	e. Breathe out through your				
	Statistical State of the Control of	rug Guide for Nurses				
		oination of ipratropium ol. "Patient and Family				
	Teaching" for these r					
		ncludes but is not limited to				
		se mouth with water after				
	each mhalallon dose	to minimize dry mouth."				
		nd, A. H., & Sanoski, C.A.				
É	(2011). Davis's drug Philadelphia PA	guide for nurses (12th ed.). : F.A. Davis.				
	epinchestrus erranes erranes este a residentativo este la	om, the administrative staff the findings as stated above.				
	No further information	on regarding this issue was				
		ey team prior to the exit				
	Label/Store Drugs a		F 761		m, thir.	
SS=D	CFR(s): 483.45(g)(h)(1)(2)		RECEIVE	D	
		of Drugs and Biologicals			i .,	
ľ	Drugs and biologica	Is used in the facility must be				

VDH/OLC

labeled in accordance with currently accepted

professional principles, and include the

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED			
		495143	B. WING	C 06/04/2018			
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS CITY, STATE, ZI				
MARTINS	VILLE HEALTH AND RE	HAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE			
F 761	§483.45(h)(1) In according personnel to have according to have according to the Comprehensive In Control Act of 1976 abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMENT by: Based on observation document review, the that drugs were labe	y and cautionary expiration date when of Drugs and Biologicals ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys. 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 aution systems in which the nimal and a missing dose can on, staff interview, and facility a facility staff failed to ensure led in accordance with rofessional principles on 1 of	F 761 1. Combivent Respimat Inha 05/30/2018. 2. Residents that reside in the potential to be effected by the 3. Nursing Staff re-educated labeling and storage of mediwith currently accepted prof DON and Human Resources and 6/13/2018. Pharmerical conducted by Unit Manager Unit medication carts 5 x a with the proper labeling and stora 4. Results of audits will be be Quality Assurance Performs (QAPI) Meeting for review implemented as indicated.	e facility have the his deficient practice. regarding proper cations in accordance dessional principles by a Director on 6/12/2018 Cart Audit to be as and/or Designee of week x 8 weeks to ensure age of medications. Brought to monthly/quarterly once Improvement			
	The facility staff faile Respimat inhaler wit	d to label a Combivent h a discard date.	QFC	EIVED			
	Combivent Respima	m, the surveyor observed a t inhaler on the medication ig that had been used was					

not dated. The surveyor spoke with LPN (licensed practical nurse) #1 in reference to the undated

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

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
	ROVIDER OR SUPPLIER	HAB	1	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET IARTINSVILLE, VA 24112	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 761	the inhaler and agree date written on the Co. The manufacturer's ginformation that inclus "Write the discard dat from the date the card. On 6/4/18 at 4:02 pm made aware of the is	inhaler. LPN #1 looked at d that there was no discard ombivent Respirat inhaler. guidelines contains des but is not limited to: se on the label (3 months tridge is inserted)." , the administrative staff was sues as stated above. In regarding this issue was y team prior to the exit	F 761		
	Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance opposessional standard	dentifiable Information 483.70(i)(1)-(5) Int-identifiable information, elease information that is to the public, elease information that is to an agent only in intract under which the agent disclose the information the facility itself is permitted	F 842	1. Resident #92's medication was discontinu physician on 5/3/2018. Resident #48's aller updated on 5/30/2018 to reflect that resident not have an allergy to Gabapentin. 2. Residents that reside in the facility have to potential to be effected by this deficient practice. 3. Nursing Staff re-educated regarding main a complete and accurate medical record by loand Human Resources Director on 6/26/201 Chart Audits to be conducted by Unit Mana and/or Designee 5 x a week x 8 weeks to enthe facility accurately maintains medical record. Results of audits will be brought to month Quality Assurance Performance Improveme (QAPI) Meeting for review and recommend implemented as indicated.	gy list I does he etice. Itaining DON 8. ger sure Fords. Illy/quarterly nt
	(i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically or	e; and		RECEIVED	

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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 _____ C 495143 B WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 842 Continued From page 112 F 842 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse. neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-(i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services

(iv) The results of any preadmission screening

and resident review evaluations and

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CENTERS FOR MEDICARE & MEDICAID SERVICES			ann attation.	OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	to the second se	STR	FET ADDRESS. CITY, STATE, ZIP CODE	#50 ⁹⁴²⁷⁹ 000,009
MARTINS	VILLE HEALTH AND R	REHAB		7 SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (FACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 842	(v) Physician's, nui professional's prog (vi) Laboratory, rad services reports as This REQUIREME by: The facility failed the medical recored for (Residents #92 and Findings included: 1. For Resident #9 ensure a complete The facility staff fail accurate Physician Resident #92 was admitted on 8/19/1 included, but were hypotension, synchracture of the left indepression. The most current Massessment locate Medicare 30 Day Massessment Refer The facility staff co Cognitive Summer also coded that Reassistance (3/2) w (ADL's). On May 30, 2018 and Services in the Residence of the Reassistance (3/2) w (ADL's).	inducted by the State; rise's, and other licensed gress notes; and diology and other diagnostic is required under §483.50. NT is not met as evidenced its maintain an accurate or two out of 45 residents id #48).	F 842		

orders on 5/8/18.

the clinical record produced signed physician

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
** ** ** ** ** ** ** ** ** ** ** ** **		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	(<u>)</u>	C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	7) 144 144 144	STF	REET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND RE	нав	0.00000	77 SPRUCE STREET ARTINSVILLE, VA 24112	
(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 CORE (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 842	Continued From pag	e 114	F 842		
	two telephone orders telephone orders rea Tablet Delayed Relea Sodium) Give 1 table related to MAJOR DE RECURRENT, UNSE 10:25 TraMADol HCI tablet by mouth every 1/2 tab (tablet) (25mg; hours prn (as needed). Further review of the POS's did not docum Depakote and Trama	d "5/2/18 10:25 Depakote ase 125 MG (Divalproex at by mouth two times a day EPRESSIVE DISORDER, PECIFIED (F33.9). 5/2/18 Lablet 50 MG Give 0.5 y 4 hours as needed for Pain 10 po (by mouth) q (every) 4 dd)." (sic) signed and dated, 5/8/18, then that the orders for idol had been transcribed to is did not include the orders			
	the Unit Manager, wh Nurse, that Resident inaccurate. The surve physician telephone of Depakote ordered 57, signed and dated, 57, reviewed Resident #1 UM. The surveyor sp the POS's signed and include the physician Tramadol and Depak the UM that the order Depakote were obtain have been transcribed stated that she had of about three weeks ar	44 a.m., the surveyor notified no was a Licensed Practical #92's POS's were reyor notified the UM that orders for Tramadol and 2/18 were not on the current 8/18, POS's. The surveyor 92's clinical record with the pecifically pointed out that did dated 5/8/18 did not telephone orders for ote. The surveyor notified res for the Tramadol and ned on 5/2/18 and should did to the POS's. The UM why worked at the facility for and did not know why the transcribed to the POS's			in S

On May 31, 2018 at 2:50 p.m., the survey team

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		1/AK - SE:	OMB NO. 0938-0391
STATEMENT	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLF CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		1			С
		495143	B WING_		06/04/2018
NAME OF PI	ROVIDER OR SUPPLIER	1 		STREET ADDRESS CITY, STATE ZIP CODE	
				1607 SPRUCE STREET	
MARTINS	VILLE HEALTH AND REI	HAB	LINE LINE	MARTINSVILLE, VA 24112	110.0
(X4) ID PREFIX TAG	EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS REFERENCED TO THE APPROPRI DEFICIENCY I	BE COMPLETION
F 842	Continued From page	e 115	F 84	42	
	1) Property and American American Company	trator (ADM), Director of			
		orate Compliance Nurse			
	The second secon	notified the Administrative			
	Team (AT) that the fa	acility staff failed to ensure a			
	complete and accura				
		urveyor notified the AT that			
	The state of the s	to transcribe physician			
	The state of the s	ained on 5/2/18 to the POS's			
	that were signed by t	the physician on 5/8/18.			
	No additional informa	ation was provided prior to			
		to why the facility staff failed			
	to ensure a complete	and accurate clinical record			
		ne facility staff failed to			
	ensure complete and				
	2004-20 10 000 900 000 000 000 000 000 000 000	iled to maintain an accurate			
		sident # 48. The clinical			
		Resident # 48 had an active			
	allergy to Gabapentin	~			
	medication as prescr	ribed by the physician.			
	Resident # 48 was a	dmitted to the facility on			
	3/22/18. Diagnoses in	ncluded but were not limited			

cognitively intact.

constipation.

to: idiopathic peripheral autonomic neuropathy, fibromyalgia, anxiety disorder, hypertension, and

assessment with an ARD (assessment reference date) of 4/12/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 48 had a BIMS (brief interview for mental status) score of 14/15,

The clinical record for Resident # 48 was reviewed on 5/29/18 at 4:33 pm. The most recent MDS (minimum data set) assessment for Resident # 48 was a significant change

which indicated that Resident # 48 was

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CENTERS FOR MEDICARE & MEDICAID SERVICES				2	OMB NO. 0938-0391
S 400 153477		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING	-	C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
MARTINS	VILLE HEALTH AND RE	нав	0.000,000	7 SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIFS CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 842	Continued From page	e 116	F 842		
	On 5/29/18 at 4:33 pm, the surveyor observed allergies handwritten on the front of Resident # 48's clinical record. Allergies included but were not limited to "Gabapentin."				
	signed on 5/2/18 for (milligrams) (Gabape at bedtime for neurop as a current allergy of	current order that was "Neurontin Capsule 100 mg entin). Give 100 mg by mouth pathy." "Gabapentin" is listed on the signed physician's dent # 48 that was signed by /18.			
	On 5/30/18 at 12:00 pm, the surveyor spoke with LPN #4 (licensed practical nurse) about the resident having an allergy to Gabapentin, yet being administered the medication. LPN # 4 stated that the medication was not given during her time working. LPN #4 went into Resident # 48's room and asked her if she was aware that she had an allergy to Gabapentin. Resident # 48 stated to LPN # 4 that she is not allergic to Gabapentin and has been taking the medication. On 5/30/18 at 2:00 pm, the surveyor spoke with				
	the DON (director of aware of the findings	nursing) and made her as stated above.			
	surveyor with a copy written on 3/30/18 at stated "(Pharmacy na rsd (resident) has alle allergy. MD (medical stated continue med observe." The survey	m, the DON provided the of a progress note that was 7:15 pm. The progress note ame withheld) called stated ergy to gabapentin. rsd has doctor) notified of allergy and monitor. Will continue to yor asked the DON if aking Gabapentin with no			

DON stated "No."

issues would this be considered a true allergy.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		01 (102)	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BJILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	a de la companya de l	495143	B. WING		C 06/04/2018
	ROVIDER OR SUPPLIER VILLE HEALTH AND REH	HAB	de a series a series	STREET ADDRESS, CITY, STATE ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	D BE COMPLETION
F 842	Continued From page	e 117	F 8	42	
		m, the administrative team he findings as stated above.			
		n regarding this issue was ry team prior to the exit			
		& Control	F 8	 Residents #109 and #101 MD notified to follow infection control guidelines. No noted. 	
	development and trandiseases and infection program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visitor.	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the members of communicable ins. prevention and control blish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals		2. Residents that reside in the facility hav potential to be effected by this deficient p 3. Nursing staff completed Relias Learnir regarding Infection Control by 06:15:201 Human Resources Director re-educated sin regards to no lanyards and nothing han name tags on 06/15/2018. DON will obseichanges 3 x a week x 8 weeks to ensure the maintenance of the infection and preventing program. 4. Results of audits will be brought to modular equatority Quality Assurance Performance (QAPI) Meeting for review and recomme implemented as indicated.	oractice. Ing Training 8. DON and Itaff ging from Inve dressing the ion control Inthly Improvement
	providing services und arrangement based up conducted according to accepted national star	pon the facility assessment to §483.70(e) and following			
	procedures for the probut are not limited to:	standards, policies, and ogram, which must include.			W .

possible communicable diseases or

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495143	B WING		06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	86	STI	REET ADDRESS, CITY, STATE, ZIP CODE	
MARTING	VILLE HEALTH AND RI	CUAD	160	77 SPRUCE STREET	
III/III IIII	TICLE HEALITI AND IN	LIAD	M.A	ARTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULI R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 880	Continued From page	ge 118	F 880		
	60 69 60	ey can spread to other	. 000		
	persons in the facilit	And the control of th			
	35 San Anna Anna Anna Anna Anna Anna Anna	om possible incidents of			
	communicable disea	ase or infections should be			
	reported;				
		ansmission-based precautions			
		event spread of infections;			
		solation should be used for a			
	resident; including b	ration of the isolation,			
		infectious agent or organism			
	involved, and	and a gold of organism			
	(B) A requirement th	at the isolation should be the			
	least restrictive poss	sible for the resident under the			
	circumstances.				
		es under which the facility			
		yees with a communicable			
		skin lesions from direct ts or their food, if direct			
	contact will transmit				
		e procedures to be followed			
		lirect resident contact.			
		tem for recording incidents			
		facility's IPCP and the			
	corrective actions ta	ken by the facility.			
	§483.80(e) Linens.				
	Personnel must han	dle, store, process, and			
		s to prevent the spread of			
	infection.				
	§483.30(f) Annual re	eview.		RECEIVE	-
		uct an annual review of its		Dan Charles	
	IPCP and update the	eir program, as necessary.		**************************************	T.
		T is not met as evidenced			Ī
	by:	PARAMPERATUR REPORTED IN TO AN		YDHIOL	* *
	Based on staff inter	view, clinical record review,		the same of the same	to se

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

and during a medication pass and pour

Event ID 56XM11

Facility ID: VA0159

If continuation sheet Page 119 of 126

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CENTER	S EUD MEDICADE &	MEDICAID SERVICES			OMB NO. 0938-0391	
855 XISO	ARC 00.0		NO MILETINE CO	NICTRICTION	(X3) DATE SURVEY	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUILDING		COMPLETED	
		495143	B WING		C 06/04/2018	
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ET ADDRESS, CITY, STATE, ZIP CODE		
			1607	SPRUCE STREET		
MARTINS	VILLE HEALTH AND RE	HAB	MAR	RTINSVILLE, VA 24112	SANOTA S	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL (SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COVALETION	
F 880	Continued From page	e 119	F 880			
	5.80 (80	ity staff failed to follow	1 000			
		control guidelines on the				
		room and for two of 45				
	Residents, Resident	#109 and #101.				
	The findings included	L _s				
	1. For Resident #109	, LPN (licensed practical				
		pill with her bare hands prior			0	
	to administering the medication to the Resident.					
	had been admitted to Diagnoses included.	but were not limited to, a, allergic rhinitis, chronic				
	Section C (cognitive)	patterns) of the Residents				
		num data set) assessment				
		ment reference date) of				
		BIMS (brief interview for				
	mental status summa	ry) score of 15.				
	On 05/29/18 beginning	ng at approximately 4:30				
		served LPN #1 prepare and				
		#109's medications. When				
		nts diltiazem LPN #1 was				
		medication out of the blister				
		bare hands, and drop it into			ļ	
		ong with the Residents			ļ 1	
		cations, LPN #1 was then				
	medications in the cu	eyor to administer all the p to the Resident.				
		on, the surveyor asked LPN				
		medication into her bare				
		t into the cup. LPN #1 stated				

she had not realized she had done this and then

stated she had used hand sanitizer.

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CENTERS FOR MEDICARE & MEDICAID SERVICES			1000 \$1000 ANDOS TO	OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		C 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER		STRE	EFT ADDRESS, CITY, STATE, ZIP CODE	3 N 3 N 3 N 3 N 3 N 3 N 3 N 3 N 3 N 3 N
MARTINS	VILLE HEALTH AND RE	HAB	50 A CONTRACTOR AND A C	SPRUCE STREET RTINSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 880	Continued From pag	e 120	F 880		
	an interview with the who was the designa The DON verbalized would have expected medication in the shall be sha	oximately 9:00 a.m., during DON (director of nursing) ated infection control nurse. to the surveyor that she did the nurse to discard the arps container. Decedure titled "PREVENTING DRS ABC's Quick Reference unch pills directly into the med at med with your fingers"			
		ontrol during a meeting with 05/31/18 at approximately			
	provided to the surve conference.	12 The Control of the			
	3/1/18 with the follow limited to anemia. co failure, high blood pr Disease, End Stage depression. On the with an ARD (Assess 3/26/18, the resident BIMS (Brief Interview 15 out of a possible was also coded as re-	admitted to the facility on wing diagnoses of, but not bronary artery disease, heart essure, Peripheral Vascular Renal Disease, diabetes and MDS (Minimum Data Set) sment Reference Date) of twas coded as having a w for Mental Status) score of score of 15. Resident # 101 equiring extensive assistance of disease of the score of the			

and being totally dependent on 2 staff members

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

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER:SUPPLIER:CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		OATE SURVEY OMPLETED C 06/04/2018
NAME OF PROVIDER OR SUPPLIFR MARTINSVILLE HEALTH AND REHAB			STRFFT ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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F 880

On 5/31/18 at 11:30 am, the surveyor conducted an observation of wound care that was performed by the wound care nurse on Resident #101. The wound care was performed as ordered by physician but the wound care nurse's name badge touched the dirty dressing to the resident's stump when removed by the nurse. Then when the clean dressing was applied to the resident's stump, the name badge touched the clean dressing. The nurse did not clean the name badge. After the dressing was applied, the surveyor interviewed the wound care nurse. The surveyor asked the nurse where her name badge was while she bent over to perform the dressing change to the resident's stump. The nurse stated, I don't know, it is attached to the top of my shirt." The surveyor notified the nurse that the name badge touched the dirty dressing and then touched the clean dressing. The nurse stated, "Oh, I see when I bend over the badge is swinging and it could touch the dressings."

At 4 pm, the surveyor notified the administrative team of the above documented findings. The surveyor requested a copy of the facility's policy regarding to infection control to be used when performing wound care.

On 6/4/18 at 2:15 PM, the surveyor was provided a copy of the policy titled "Exposure Contro! Plan: Decontamination". Under the Procedure section, #2 read: All environment surfaces or items that contact or are likely to contact the resident ...shall be cleaned with an approved disinfectant ..."

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

3. The facility staff failed to follow infection

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STATEMENT OF DEFICIFNCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATÉ SURVEY COMPLETED		
		495143	B WING		C 06/04/2018		
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				STREET ADDRESS CITY, STATE ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION			
F 880	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		F 880				
	empty water cup into	the medication cup and the wastebasket on the # 2 did not sanitize or wash		REC	EIVED		
	LPN #2 as she prepa	n, the surveyor observed ared pain medications for had not washed or sanitized		VDH	- 10% 1/OLC		

According to the facility Policies and Procedures for "Disposable Non-Sterile Gloves," Procedure

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
-		495143	B WING		C 06/04/2018		
NAME OF P	ROVIDER OR SUPPLIER	-	STF	REET ADDRESS, CITY STATE, ZIP CODE	· ·		
MARTINSVILLE HEALTH AND REHAB			1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 880	"4. Indications for glor potential for cleaning material, urine, blood Also use gloves wher to Standard Precautic include: infected material, urine, blood wounds, tissues, open membranes. 5. Remove gloves and 6. Wash hands. 7. Change gloves and residents and betwee procedures performed resident." On 5/31/18 at 3:40 private was made aware of the wash made aware of the wash washided to the survey conference on 6/4/18 4. Facility staff failed to policy for hand washided to the survey conference on and water on the surfit off with paper toweld. LPN II the exited the survey washided to the survey washided to the survey conference on 6/4/18.	les but is not limited to: ve use include the actual or or touching blood, fecal y body fluids or drainage, nother body fluids that apply ons are present. These erial from isolation residents, in skin or mucous In dispose of, In dispose of, In dispose of, In dispose of, In the administrative team the findings as stated above. In regarding this issue was by team prior to the exit in to follow the infection control ong, On 6/4/18 at 10:00 AM to clean off an overbed from With her bare hands of the table, which had it. She then put some soap face of the table and cleaned is. I room with a pill cup full of	F 880	RECEIVES			
medication for another resident and entered their room without washing her hands or using hand sanitizer.				Alfrits diw VDH/OLG			

This was reported to the facility DON on 6/3/18 at 11:00 AM. She said the facility infection control policy required staff members to wash their hands

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING_ C 495143 B WING 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFFRENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 124 F 880 in between administering care to residents and when going from one room to another. No additional information was provided prior to exit. F 921 Safe/Functional/Sanitary/Comfortable Environ F 921 1. Housekeeping has cleaned resident rooms to 7/4/2018 SS=E CFR(s): 483.90(i) ensure proper cleanliness. 2. Residents that reside in the facility have the §483.90(i) Other Environmental Conditions potential to be effected by this deficient practice. The facility must provide a safe, functional, 3. Housekeeping staff re-educated on the proper procedures for cleaning resident's rooms on sanitary, and comfortable environment for 6/15/2018. Care Keeper Rounds to be completed by residents, staff and the public. Department Heads 5 x week x 8 weeks to ensure a This REQUIREMENT is not met as evidenced clean, comfortable and homelike environment for residents in the facility. Based on observation and staff interview it was 4. Results of audits will be brought to monthly/quarterly determined that the facility staff failed to ensure a Quality Assurance Performance Improvement clean, comfortable environment and homelike (QAPI) Meeting for review and recommendations environment on 3 of 3 units. The facility had a implemented as indicated, pervasive odor of urine on three of three units. The findings included: On May 29, 2018 at 2 p.m., the survey team entered the facility and were escorted to the conference room. This surveyor noted a pervasive odor of urine in the hallways on the main floor of the facility. On May 29, 2018 at 2:45 p.m., the surveyor made an initial tour of the facility. The surveyor noted a pervasive odor of urine in the hallways on all three units in the facility. On May 30, 2018 at 8 a.m., the surveyor noted a VDH/OLC pervasive odor in the hallways on the two units on the main level of the facility. The surveyor took the elevator down to the lower level of the facility.

The surveyor noted a pervasive odor of urine in

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06/04/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

C

 495143
 B WING

 NAME OF PROVIDER OR SUPPLIER
 STREET ADDRESS, CITY, S'

MARTINSVILLE HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
1607 SPRUCE STREET

MARTINSVILLE, VA 24112

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

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

(X5) COMPLETION DATE

F 921 Continued From page 125

the hallways on the unit on the lower level of the facility.

On May 31, 2018 at 2:50 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the hallways on all three units had a pervasive odor of urine.

No additional information was provided prior to exiting the facility as to why the facility had a pervasive odor of urine throughout the facility.

F 921

RECEIVED

VDH/OLC