STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 9/6/17 through 9/7/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 8 certified bed facility was 5 at the time of the survey. The survey sample consisted of 4 current Resident reviews (Resident #1 through Resident #4) and 1 closed record review (Resident #5).

F 156 SS=C 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES — F 156

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this

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

Anita H. ____ BSN RN ECU Director 10/10/17

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

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section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and

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advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

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(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and

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responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

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(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to post information regarding the local ombudsman contact information and failed to post contact information on the local area on aging.

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F 156	Continued From page 6 The findings included: The facility staff failed to ensure the "Resident Rights" poster contained information on the local long-term care ombudsman and the local area on aging. During the initial tour of the facility on 9/6/17 at 9:15 a.m., the surveyor observed the Resident Rights poster enclosed in the bulletin board on the wall near the ECU (extended care unit) nurse's station. The surveyor did not observe information on the local long-term care ombudsman and the local area on aging. The surveyor observed the "Resident Rights" poster again on 9/7/17 at 8:00 a.m. The area where the local ombudsman contact information should have been located was blank. The area where information on the local area on aging was blank. The poster was dated November 21, 2016. The surveyor interviewed registered nurse #1 on 9/7/17 at 8:00 a.m. R.N. #1 stated that information could possibly be found in the ECU admission packet. The surveyor and R.N. #1 reviewed the packet and found no information for the local long term care ombudsman or the local area on aging. The surveyor informed the CNO (chief nursing officer), administrative registered nurse #1, and administrative registered nurse #2 of the missing information from the "Resident Rights" poster on 9/7/17 at 11:50 a.m. The C.N.O. stated the information on the local ombudsman was incorrect on the local ombudsman website and the facility had called to obtain the name of the	F 156	1. The corrective action was accomplished & posted for all affected residents on 9/7/17. 2. The corrected "Resident Rights" poster including names & contact information for local long-term care omsbudsman & the local area on aging is posted in public view for all staff, visitors and current/future residents information. 3. In the future, the poster will remain posted including all information and checked quarterly by unit director of nursing or designee. The schedule will coincide with quarterly performance improvement reporting. 4. The director of nursing or designee will report at the time of the performance improvement meeting that the omsbudsman and local area on aging contacts have not changed. 5. The corrective action was completed on 9/7/17. The monitor will continue to be reported at the performance improvement quarterly meeting.	

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F 156	Continued From page 7 current local long term care ombudsman. The C.N.O. stated the information contained a previous ombudsman for the area. All agreed the Resident Rights poster had missing information. No further information regarding the incorrect postings was provided to the surveyor prior to the exit conference on 9/7/17.	F 156		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 356		

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daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure the daily staffing information posted contained the name of the facility, the current census, the total hours worked and the actual hours worked for each nursing discipline.

The findings included:

The facility staff failed to ensure the daily staffing information posted contained the name of the facility, the census, the actual hours worked and the total hours worked.

During the initial tour of the facility on 9/6/17 at 9:15 a.m., the surveyor observed the staffing sheet. The staffing information was written on an erasable board and was enclosed in the bulletin

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F 356	Continued From page 9 board on the wall near the ECU (extended care unit) nurse's station. The surveyor did not observe the name of the facility, the current census, the total hours worked and the actual hours worked on the erasable board. The surveyor interviewed registered nurse #1 on 9/7/17 at 8:00 a.m. R.N. #1 stated that information was all that was written on the board. The surveyor informed administrative registered nurse #2 of the staffing requirements on 9/7/17 at 9:30 a.m. and administrative R.N. #2 provided the surveyor with the "Hospital Staffing Roster" dated 9/6/17. The staffing for ECU (extended care unit) contained the names of registered nurse #1 and certified nursing assistant #3. The roster did not contain the name of the facility, census, actual hours worked or total hours worked. The surveyor informed R.N. #2 that the posted staffing information was to be retained for 18 months. The surveyor informed the C.N.O. (chief nursing officer),administrative registered nurse #1, and administrative registered nurse #2 of the above concern on 9/7/17 at 11:50 a.m. No further information regarding the staff postings was provided to the surveyor prior to the exit conference on 9/7/17.	F 356	1. Corrective action accomplished by adding hospital name, census, actual hours/total hours worked and is posted in plain view of residents, updated at the end of each shift and will be retained in the nursing office for 18 months. 2. The future affected residents will also see this form posted in plain view. 3. The deficient practice will be monitored as part of a performance improvement monitor and reported quarterly to the performance improvement meeting for not less than 6 months or until 100% compliance is achieved for 6 months. 4. See third bullet, after 6 months, the process will be spot-checked monthly when preparing performance improvement data. 5. The initial posting occurred on 9/7/17, including all required elements. The retention of forms began same day, 9/7/17.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		

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F 371	Continued From page 10 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility staff failed to label, date and store food in the refrigerator and failed to ensure facility staff with beards wore beard restraints. The findings included: The surveyor toured the facility kitchen 9/6/17 beginning at 9:40 a.m. with the dietary manager and other #5. During the initial tour of the facility the following items were observed: In the reach in refrigerator, a stainless steel pan held a package of roast beef. The package had a stamp that read "6/21/17." The package itself read "Use by or freeze by 8/4/17." The pan containing the roast beef had a layer of roast beef	F 371	1. Policy has been modified to address concerns of label and dating, and the use of beard nets. Added the following to the policy - Beard nets are to be worn during food preparation and serving if facial hair is present. -Verify label and dating prior to use. Discard any food product that has not been resealed properly, is unlabeled, or out of date -Frozen items shall be maintained in the original packaging to protect food from freezer burn and to maintain food labeling data from the manufacturer and/or the distributor. 2. Policy has been modified to address concerns of label and dating, and the use of beard nets. Added the following to the policy -Beard nets are to be worn during food preparation and serving if facial hair is present. -Verify label and dating prior to use. Discard any food product that has not been resealed properly, is unlabeled, or out of date -Frozen items shall be maintained in the original packaging to protect food from freezer burn and to maintain food labeling data from the manufacturer and/or the distributor	

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F 371	Continued From page 11	F 371	3. Policy Change: Frozen items found to be unlabeled due to the removal from the original packaging that includes manufacture date and distribution delivery date. Date labels do not adhere well to frozen food, therefore, this change of procedure will insure that everything remains labeled and dated. Policy Change: Beard nets are to be worn by anyone with facial hair if they are in the performance of food preparation or serving of food. Individuals identified as having facial hair has elected to shave his beard. Policy Change: Food will be checked for date prior to any use. Unsealed and unlabeled product will be discarded. Refrigerators and freezers will be checked for unlabeled and opened food items once a week for the next six months. Report auditing data to performance improvement committee.	

juices; however, the surveyor was unable to observe when the roast beef had been placed in the reach in refrigerator. There was no date found on the package. Other #5 stated the roast beef would be thrown away. "I don't know when it was pulled. It must have got missed."

In a second reach in refrigerator, the surveyor observed an opened bag of multiple pieces of bread. The bag of multiple pieces of bread was not labeled as to the contents or dated and was not securely tied.

Also, the surveyor observed 6 bags of bagels. There was no date or label on the bagels. The dietary manager stated the bags of bagels had been removed from their original boxes that contained all the product information. The dietary manager stated the kitchen will return to leaving in the original packaging.

The surveyor also observed an opened bag of vegetable medley that had no date when opened. The bag was not securely tied and the surveyor could easily see the bag's contents. Other #5 stated the bag should have been labeled when opened.

The surveyor returned to the kitchen at 9/6/17 at 11:30 a.m. to do the tray line temperatures. The surveyor observed other #3 (the cook) as the tray line temperatures were checked. The surveyor observed other #3 with facial hair and a mustache. Other #3 did not have a beard restraint to cover the facial hair. When asked about the beard restraint, other #3 stated didn't need to wear one because of the length of the beard. Other #3 stated a beard restraint was only worn if the beard was longer than ¼ inch. Other

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F 371	Continued From page 12 #3 stated it didn't matter to him. "I'll wear a beard restraint or shave it." The surveyor informed the chief nursing officer (CNO), administrative registered nurse #1, administrative registered nurse #2, and the interim chief executive officer (CEO) of the above observations on 9/6/17 at 4:30 p.m. The surveyor requested the facility policy on the storage of foods and label and dating food items. Also, information on beard restraints. No further information was provided prior to the exit conference on 9/7/17.	F 371		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

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F 520	Continued From page 13	F 520		

identifying issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to ensure the Quality Assessment and Assurance (QAA) Committee met at least quarterly and the designated key members of the committee attended quarterly.

The findings included:

The facility staff failed to ensure the director of nursing, a physician and three other staff members attended the meetings quarterly and that the QAA meetings were held quarterly.

The surveyor met with the Director of Clinical Effectiveness (administrative registered nurse #1) on 9/7/17 at 10:50 a.m. to discuss the Quality Assessment and Assurance program. Administrative registered nurse #1 stated that

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F 520	Continued From page 14	F 520	1 Corrective action accomplished 9/13/17 by having a designated QAA quarterly meeting that includes the medical director or designee, the unit manager of ECU and three other staff members present, one of which must be an administrator or in a leadership role. 2 The future affected residents will have access to QAA meeting attendance as requested from unit manager 3 The deficient practice will be monitored by the new unit director as part of a performance improvement monitor and reported quarterly to the performance improvement meeting for not less than six months or until 100% compliance is achieved for six months 4 After six months, the process will be spot-checked 5 QAA 9/13/17 meeting occurred and all required elements were in place	

committee met on the extended care unitand she was not part of that meeting. The current manager for that unit was not available during the survey 9/6/17 through 9/7/17 to interview.

The surveyor and the Director of Clinical Effectiveness reviewed the QAA information on 9/7/17.

The QAA meeting held 12/14/16 did not include three other staff members. The sign in roster included the medical director, the unit manager of ECU, and two other members.

The QAA meeting designated as a quarterly meeting was held 2/22/17. This meeting did not include the unit manager/DON (director of nursing).

March 2017 had four weekly meetings; however, none were designated as a QAA meeting and did not include the key members of the committee.

The QAA meeting held 4/5/17 did not include the unit manager/DON. Three other weekly meetings were held; however, none had the required key members present.

May 2017 had three weekly meetings; however, none were designated as a QAA meeting and had the required key members.

A QAA meeting was held 6/28/17. The physician was not present at the meeting.

The surveyor interviewed the Director of Clinical Effectiveness on 9/7/17 at 11:10 a.m. The director stated the unit manager tried to coordinate a date to meet when the medical

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F 520	Continued From page 15	F 520		

director would be available. The director of clinical effectiveness stated the meetings were held on a day when the medical director had surgery. She also stated the unit manager was clocked in to the area but probably didn't sign the roster.

The surveyor informed the chief nursing officer (CNO), the administrative registered nurse #1/Director of Clinical Effectiveness, and administrative registered nurse #2 of the concern with the QAA program during the meeting on 9/7/17 at 11:50 a.m.

No further information was provided prior to the exit conference on 9/7/17.