STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409 LEBANON, VA 24266**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/9/17 through 05/11/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 49 at the time of the survey. The survey sample consisted of 1 current Resident reviews (Residents 1 through 11 and 17) and 5 closed record reviews (Residents # 12, through #16).	F 000		
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(c)(6)(8)(g)(12), 483.24(a)(3) 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 155		6/23/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/31/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 155 — Continued From page 1

resident’s option, formulate an advance directive.

(ii) This includes a written description of the facility’s policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual’s resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident’s advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to have a completed DDNR (Durable Do Not Resuscitate) for 1 of 17 residents in the survey sample (Resident #1).

F 155 (Plan of Correction):

Kissito Healthcare shares the state's focus on the health, safety, and well being of facility residents. Although the facility does not agree with some of the findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 155	Continued From page 2 The findings included: The facility staff failed to have a completed DDNR (Durable Do Not Resuscitate) in the clinical record for Resident #1. Resident #1 was readmitted to the facility on 2/24/17 with the following diagnoses of, but not limited to anemia, heart failure, anxiety disorder, depression, disorders of the prostrate and hypothyroidism. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/17 coded the resident as having short term and long term memory problems with decision making being moderately impaired. Resident #1 was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the clinical record review performed by the surveyor on 5/10/17, the surveyor noted that the DDNR in the clinical record of Resident #1 was not dated. The administrative team was notified of the above documented findings on 5/10/17 at approximately 2 pm by the surveyor. The director of nursing stated "There's a sticker on the top of it that has a date on it." The surveyor stated "It was a sticker from the hospital that had an admission date on it. The DDNR was not dated at the time it was signed." No further information was provided to the surveyor prior to the exit conference on 5/11/17.	F 155	and conclusions of the surveyors, we have implemented a plant of correction to demonstrate our continuing effort to provide quality care to our residents. Resident□s #1 DDNR form was completed on 5/30/17 An audit for current residents in the center was completed to ensure DDNR forms have been completed in their entirety. Clinical staff was educated by the Director of Nursing/Designee on the process for completion of DDNR forms including the completion of each section and the form is dated in the areas requiring a date. The Director of Nursing/Designee will review 5 charts per week to ensure DDNR forms are completed in their entirety. In addition, during morning meeting, new admissions and new orders for DDNR forms will be reviewed to ensure the DDNR forms are completed appropriately. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 309 SS=D	Continued From page 3 WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 309	Continued From page 4 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 3 of 17 residents (Resident's #6, #2, and #3). The findings included. 1. For Resident #6, the facility staff failed to follow physician's orders in regards to diabetic management. The record review revealed that Resident #6 had been admitted to the facility 03/21/16. Diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, diabetes, chronic obstructive pulmonary disease, anxiety disorder, and neuromuscular dysfunction of the bladder. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section I (active diagnoses) was checked to indicate the Resident had an active diagnosis of diabetes. The Residents comprehensive care plan included the focus area at risk for hyper/hypoglycemic reactions...related to diabetes. Interventions included diabetes medication as ordered by doctor and monitor lab values per physician order. The clinical record contained an order summary report that included an order for novolog insulin per sliding scale four times a day. For a BS (blood sugar) of 301-400 the facility nursing staff was to administer 8 units of insulin and for a BS	F 309	Resident #6s attending physician was notified of the incorrect dosage of insulin being administered on 5/7/17 and the omission of a blood sugar for 1900 on 4/24/17. No new orders. No action taken for resident #2 or resident #3 due to the time frame had already passed. An audit of the current residents in the center was conducted for the past 30 days for residents receiving blood sugars and sliding scale insulin to ensure documentation of blood sugars and administration of sliding scale insulin as per physician orders. In addition, bowel records for current residents in the center for he last 30 days will be audited to ensure bowel protocol was implemented for residents without a bowel movement for three days. Licensed nurses have been educated by the Director of Nursing/designee on the 5 R(s) of medication administration including sliding scale insulin and blood sugars. In addition, licensed staff was educated on bowel protocol for residents without a bowel movement every three days. The Director of Nursing/designee will audit 5 records per week of residents with sliding scale insulin and blood sugars to ensure insulin and blood sugars are being completed as per physician orders. In addition, bowel records for 10 residents will be reviewed weekly to ensure bowel	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 309 Continued From page 5

of 401 and above 10 units of insulin.

A review of the Residents MAR's (medication administration records) revealed that on 05/07/17 at 0700 (7:00 a.m.) the nursing staff had documented the Residents BS as being 399 and had administered 10 units of insulin when the Resident should have only have received 8 units. The Residents BS at 1100 (11:00 a.m.) was documented as 286.

A review of the MAR's for 04/2017 revealed that for 04/24/17 at 1900 (7:00 p.m.) the nursing staff had not documented any BS results for the Resident or if any insulin had been administered.

The administrative staff was notified of the above in a meeting with the survey team on 05/10/17 at approximately 1:20 p.m.

On 05/10/17 at 17:36 (5:36 p.m.) the facility nursing staff documented in the Residents clinical record that they had notified the physician and daughter that the Resident had received 10 units of insulin instead of 8 units on 05/07/17.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to follow physician's standing orders concerning no bowel movements for 3 days for Resident #2.

Resident #2 was admitted to the facility on 3/20/17 with the diagnoses of, but not limited to coronary artery disease, pneumonia, septicemia, thyroid disorder and arthritis. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/27/17, the

F 309

protocol was initiated for residents without a bowel movement every third day.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 309	Continued From page 6	F 309		

resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene and being totally dependent on 2 or more staff members for bathing.

The surveyor performed a clinical record review of Resident #2's clinical record on 5/10/17 at which time the surveyor noted that the resident had not had a bowel movement for the following dates: 4/26/17 thru 4/29/17 and 5/4/17 thru 5/7/17. The surveyor reviewed the MAR (Medication Administered Record) for Resident #2 for these dates and the resident did not receive anything for not having a bowel movement for 3 days.

The surveyor asked the assistant director of nursing for the physician's standings orders for Resident #2 on 5/10/17 at approximately 11 am. The assistant director of nursing provided a copy of the physicians' standing orders for Constipation which stated the following:
"If no bowel movement in 3 days give MOM (Milk of Magnesium) 30 cc (millitiers) PO (by mouth) if no results with MOM give Dulcolax suppository one per rectum, if no results after 1 hour, give Fleets enema per rectum. If constipation recurs q3 (every 3) days routinely, you may begin Senekot-S 1 tab PO twice daily and use above interventions p.r.n. (as needed)."

The administrative team was notified of the above documented findings on 5/10/17 at approximately 2 pm by the surveyor.

No further information was provided to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409 LEBANON, VA 24266**

(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 309	Continued From page 7	F 309		

surveyor prior to the exit conference on 5/11/17.

3. The facility staff failed to follow physician's standing orders concerning no bowel movements for 3 days for Resident #3.

Resident #3 was readmitted to the facility on 12/21/16 with the following diagnoses of, but not limited to anemia, heart failure, Alzheimer's Disease, dementia, depression, insomnia and contractures. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/17, coded the resident as short term and long term memory problems and being severely impaired with decision making. Resident #3 was also coded as being totally dependent on 2 or more staff members for dressing and bathing.

The surveyor performed a clinical record review of Resident #3's clinical record on 5/10/17 at which time the surveyor noted that the resident had not had a bowel movement for the following dates: 4/11/17 thru 4/15/17 and 4/25/17 thru 4/29/17. The surveyor reviewed the MAR (Medication Administered Record) for Resident #3 for these dates and the resident did not receive anything for not having a bowel movement for 3 days.

The surveyor asked the assistant director of nursing for the physician's standings orders for Resident #3 on 5/10/17 at approximately 11 am. The assistant director of nursing provided a copy of the physicians' standing orders for Constipation which stated the following:
If no bowel movement in 3 days give MOM (Milk of Magnesium) 30 cc (millitiers) PO (by mouth) if no results with MOM give Dulcolax suppository

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 309	Continued From page 8 one per rectum, if no results after 1 hour, give Fleets enema per rectum. If constipation recurs q3 (every 3) days routinely, you may begin Senekot-S 1 tab PO twice daily and use above interventions p.r.n. (as needed)." The administrative team was notified of the above documented findings on 5/10/17 at approximately 2 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 5/11/17.	F 309		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means	F 328		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 328	Continued From page 9 receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders regarding oxygen for 1 of 17 residents in the survey sample (Resident #1). The findings included:	F 328	Resident is currently receiving oxygen at 4 liters per minute as per physician order. Current residents in the center receiving oxygen have he potential to be affected. Licensed nurses have been educated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 328

Continued From page 10

Resident #1 was readmitted to the facility on 2/24/17 with the following diagnoses of, but not limited to anemia, heart failure, anxiety disorder, depression, disorders of the prostrate and hypothyroidism. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/17 coded the resident as having short term and long term memory problems with decision making being moderately impaired. Resident #1 was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

On 5/9/17 at 2:10 pm, the surveyor observed the resident's oxygen being administered to the resident by nasal cannula at 4 liters/minute.

The surveyor observed the resident in his room on 5/10/17 at 8:20 am, at which time the resident was receiving oxygen by nasal cannula at 4 1/2 liters/minute. Certified nursing assistant (CNA) #1 was in the resident's room at this time with the surveyor. CNA #1 was asked by the surveyor to look at Resident #1's oxygen and tell the surveyor what the setting is on at the present time. CNA #1 stated "It's on 4 ½ liters ..."

The surveyor reviewed the clinical record of Resident #1 on 5/10/17 at 10 am. The surveyor noted on the MAR (Medication Administration Record) for the month of May, 2017, the facility staff had documented the resident's oxygen saturation every shift with it ranging from 90 to 94%. The physician order sheets for May, 2017 were also reviewed by the surveyor and the surveyor noted that the following order was present:
"O2 (Oxygen) @ (at) 3 l/m (liters/minute) via (by)

F 328

the Director of Nursing/designee on physician orders including orders for oxygen and verifying the oxygen setting on the concentrator/tank with the physician orders. In addition, licensed nurses have been educated to document oxygen saturations and any needed changes that result in accordance with the parameters of the order.

Director of Nursing/designee will during morning rounds via direct observation 5x/week observe residents with oxygen orders to ensure the liters of oxygen being delivered to the resident matches the physician order. In addition, if the order has parameters based on oxygen saturations there is documentation in the medical record to support the amount of oxygen being delivered to the resident.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409 LEBANON, VA 24266**

(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 328	Continued From page 11 nasal cannula continuous may titrate to keep sats greater than 90 percent as needed." In reviewing the nursing documentation for the month of May, 2017, the only documentation noted in the nurses' notes are documented for 5/1/17 and timed for 12:30 pm which stated: " ...Resident on 5 liters of oxygen via nasal cannula O2 saturation 92 percent ..." The assistant director of nursing was interviewed by the surveyor on 5/10/17 at 11 am. The surveyor asked the assistant director of nursing if the nursing staff should document when the resident needed increased oxygen should they have this documented. The assistant director of nursing stated "Yes, they should have it documented in the nurses' notes." The administrative team was notified by the surveyor of the above documented findings on 5/10/17 at approximately 2 pm by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/11/17.	F 328		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of	F 504		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 504	Continued From page 12 practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician's order prior to obtaining the laboratory test for 3 of 17 residents (Residents #5, #1, and #8). The finding included: 1. For Resident #5 the facility staff failed to obtain physicians orders for laboratory test; a complete blood count (CBC) and a comprehensive metabolic panel (CMP). Resident #5 was admitted to the facility 8/1/16 and readmitted on 2/28/17 with diagnoses that included but not limited to schizoaffective disorder, anemia, high blood pressure, diabetes, acute kidney failure and atrial fibrillation. A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 3/7/17, the facility staff assessed the resident to understand and to be understood. She was assessed to have a cognitive summary score of 07. Resident #5's clinical record was reviewed 5/10/17, and revealed the results of CBC and CMP laboratory test done on 4/7/17, 4/14/17, and 4/14/17. However, the surveyor could not locate corresponding orders for the laboratory test. On 5/10/17, the assistant director of nurses was asked to assist in locating the orders for the labs. On 5/11/17 at 9:20 am, the assistant director of nurses said Resident #5 had an order for the lab	F 504	The physician was notified for resident #5 that a CMP/CBC was obtained on 5/10/17. No new orders. The physician was notified for resident #1 that a Thyroid Function test was obtained on 3/13/17. No new orders. The physician was notified for resident #8 that a BMP was obtained on 12/30/16. No new orders. An audit of current residents in the center was conducted for the last 30 days to ensure labs drawn had corresponding physician orders. Licensed nurses have been educated by the Director of Nursing/designee for the process for physician orders including orders for labs. Verification prior to obtaining a lab will be completed to ensure there is a corresponding physician order prior to obtaining the lab. The Director of Nursing/designee will audit 10 labs obtained weekly to ensure here is a corresponding physician order. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 504	Continued From page 13 test weekly but went out to the hospital and when she returned the weekly CBC and CMP lab test were still on the lab book and were continued without an order. On 5/11/17 at approximately 4:20 pm, the administrative staff was made aware of the CBC and CMP test obtained without orders. Prior to exit no further information was provided by the facility staff related to the lab test obtained without an order. 2. The facility staff failed to obtain a physician order prior to obtaining a Thyroid Function for Resident #1 on 3/3/17. Resident #1 was readmitted to the facility on 2/24/17 with the following diagnoses of, but not limited to anemia, heart failure, anxiety disorder, depression, disorders of the prostrate and hypothyroidism. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/17 coded the resident as having short term and long term memory problems with decision making being moderately impaired. Resident #1 was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the clinical record review performed by the surveyor on 5/10/17, the surveyor noted a laboratory test result for Thyroid function test that was performed 3/3/17 was in the clinical record. The surveyor reviewed the physician orders for Resident #1. The surveyor could not find a physician order prior to the facility obtaining this laboratory test.	F 504	conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(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 504	Continued From page 14	F 504		

On 5/10/17 at approximately 11 am, the assistant director of nursing was notified of the above findings by the surveyor.

At 1:30 pm, the assistant director of nursing stated to the surveyor that she could not find an order for this test.

At approximately 2 pm on 5/10/17, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 5/11/17.
3. For Resident #8, the facility staff obtained a BMP (basic metabolic panel) lab test when the physician had ordered a CMP (comprehensive metabolic panel) lab test.

The record review revealed that Resident #8 had been admitted to the facility 06/08/15. Diagnoses included but were not limited to chronic obstructive pulmonary disease, bipolar disorder, peripheral vascular disorder, protein calorie malnutrition, and muscle weakness.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/20/17 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points.

The clinical record contained a physician order summary sheet that included an order for the lab tests CBC (complete blood count) and CMP every December, March, June, and September. The order date was documented as 12/27/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409 LEBANON, VA 24266**

(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 504	Continued From page 15 The clinical record included the results of a CBC and BMP that had been obtained on 12/30/16. On 05/10/17 at approximately 11:00 a.m. the surveyor asked the ADON (assistant director of nursing) about the BMP lab test. On 05/10/17 at approximately 12:30 p.m. the ADON verbalized to the surveyor that they had obtained the BMP by mistake and when they realized it they obtained the physician ordered CMP. The administrative team was notified of the above in a meeting with the survey team on 05/10/17 at approximately 1:20 p.m. No further information regarding the BMP lab test was provided to the survey team prior to the exit conference.	F 504		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409** **LEBANON, VA 24266**

(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 514	Continued From page 16	F 514		

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to have a complete and accurate clinical record for 1 of 17 residents in the survey sample (Resident #2).

The findings included:

The facility staff failed to have a complete and accurate clinical record for Resident #2 concerning the resident's DDNR (Durable Do Not Resuscitate) status.

Resident #2 was admitted to the facility on 3/20/17 with the diagnoses of, but not limited to coronary artery disease, pneumonia, septicemia, thyroid disorder and arthritis. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/27/17, the

Resident□s #1 DDNR form was completed on 5/30/17.

An audit for current residents in the center was completed to ensure DDNR forms have been completed in their entirety.

Clinical staff was educated by the Director of Nursing/Designee on the process for completion of DDNR forms including the completion of each section and the form is dated in the areas requiring a date.

The Director of Nursing/Designee will review 5 charts per week to ensure DDNR forms are completed in their entirety. In addition, during morning meeting, new admissions and new orders for DDNR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH CARE CENTER	**POST OFFICE BOX 2409 LEBANON, VA 24266**

(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 514	Continued From page 17 resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene and being totally dependent on 2 or more staff members for bathing. The surveyor performed a clinical record review of Resident #2's clinical record on 5/10/17. The surveyor noted a signed and dated DDNR for 3/21/17. On the physician's order sheets for the months of April and May, 2017, there were signed physicians' orders that stated the resident was a "Full Code". On 5/9/17 there was a physician order for the resident to be a "Full Code" status and then later on in the day on 5/9/17, there was another written for the resident to be a "No Code", during which time, the resident had signed and dated the DDNR paperwork for 3/21/17 and this was on the clinical record. The administrative team was notified of the above on 5/10/17 at approximately 2 pm by the surveyor. The director of nursing stated "The code status was right on the DDNR dated for 3/21/17." No further information was provided to the surveyor prior to the exit conference on 5/11/17.	F 514	forms will be reviewed to ensure the DDNR forms are completed appropriately. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	