STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 6/21/16 through 6/22/16. 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 60 certified bed facility was 48 at the time of the survey . The survey sample consisted of 11 current Resident reviews (Residents 1 through 11) and 3 closed record reviews (Residents 12 through 14).

F 155 SS=D 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. 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 individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.

To remain in compliance with all federal and state regulations, the facility has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance.

F155

Residents' #2 and #5 DDNR forms were completed on 6/21/16.

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

Clinical staff will be educated by the Director of Clinical Services/designee on the process for completion of DDNR forms and to ensure all sections are completed.

Director of Clinical Services/designee will review 5 charts per week to ensure DDNR forms are completed in their entirety. In addition, during rning meeting new admissions and new orders for DNR will be reviewed to ensure the DDNR forms are completed appropriately.

Bob Nelson — Administrator — 7/13/16

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

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/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B WING _____	06/22/2016

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

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 out of 14 Resident's (Resident #2 and #5).
The findings included:
For Resident #2, the facility failed to accurately complete a DDNR (durable do not resuscitate) order form.
Resident #2 was admitted to the facility on 1/2/13 . Diagnoses included but were not limited to: diabetes, Bipolar, edema, atrial fibrillation, stroke, hypertension, anxiety and depression.

A review of Resident #2 ' s MOS (minimum data set) assessment with an ARD (assessment reference date) of 3/10/16, scored the resident to be a 3 in section C for his cognitive pattern.

The clinical record included a DDNR form dated 1/20/16. This form had been signed by the physician and the Resident ' s responsible party.

This DDNR read in part, "I further certify [must check 1 or 2]:
1. " The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment . (Signature of patient is required).
2. "The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision."

F 155 Continued From page 1

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

Completion Date: July 21, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X 1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 155	Continued From page 2	F 155		

The 2 had been selected for Resident #2 . Section 2 of the DDNR stated, "If you checked 2 above, check A, B, or C below." The A, B, and C boxes had been left blank.

On 6/21/16 at approximately 2:15 p. m., the LPN #1 was shown the DDNR and asked if she could identify what was wrong with the DDNR. She stated, " A or B should have been marked. "

On 6/22/16 at approximately 3:05p. m., a meeting was held with the director of nurses the administrator , and other administrative *staff* . The incomplete DDNR was discussed during this meeting.
Prior to exit no further information was provided related to the incomplete DDNR.
2. The facility staff failed to ensure Resident #S's DNR was complete.

The surveyor reviewed Resident #S's clinical record on 6/21/16 and 6/22/16 . Resident #5 was admitted to the facility 4/30/09 and readmitted 1/6/13 with diagnoses that included but not limited to chronic airway obstruction, polyneuropathy in diabetes, neurogenic bladder with suprapubic catheter, iron deficiency anemia , diabetes mellitus, cellulitis, hypertension, hyperpotassemia, urinary tract infection, sacral ulcer, left gluteal fold ulcer, and fistula of intestine with colostomy.
Resident #S's annual minimum data set (MOS) assessment with an assessment reference date (ARD) of 2/23/16 assessed the cognitive status as 8 out of 15 in Section C Summary Score.
The clinical record contained a Virginia Department of Health Durable Do Not Resuscitate (DDNR) order dated 10/22/15. The DDNR form included in the clinical record stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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

(X4) 1D 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)	(XS) COMPLETION DATE
F 155	Continued From page 3	F 155		

in part:

I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision ...
2. The patient is INCAPABLE of making an informed decision ...

If you checked 2 above, check A, B, or C below:
A While capable of making an informed decision, the patient has executed a written advanced directive...
B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf "...
C. The patient has not executed a written advanced directive...

There were no checks in any of the boxes on the DDNR form. The section at the bottom of the DDNR form had been signed by the physician and the resident

The June 2016 physician order sheet signed 6/13/16 read "DNR"
The surveyor interviewed licensed practical nurse #3 on 6/22/16 at 8:00 a.m. LP.N. #3 was asked to review the DDNR LP.N. #3 stated "There's nothing marked. These come from the hospital and should be completed there." During the interview, the surveyor asked LP.N. #3 if paperwork from the hospital was reviewed for completeness prior to placing on the clinical record. LP.N. #3 stated yes.
The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE

F 155 Continued From page 4

No further information was provided prior to the exit conference on 6/22/16.

F 279 483.20(d),483.20(k)(1) DEVELOP
279 SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.1O(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for 4 of 14 residents (Resident #1, Resident #4, Resident #5, and Resident #3).

The findings included:

1. The facility staff failed to develop a

F 155

F 279

Residents #1, #4, #5, and #3 were reviewed and deficient areas were addressed on their comprehensive care plan at the time of the survey.

An audit of care plans for current residents in the center was conducted to ensure the individual care plans reflect urinary incontinence, mood, dehydration and psychotic drug use where appropriate.

The IDT team will be educated by the Director of Clinical Services/designee on the center's policy for comprehensive care plans which includes revision of the care plans to reflect the resident's current physical and psychological status.

The Director of Clinical Services/designee will review 5 care plans per week to ensure the care plan reflects the current status of the residents. In addition new admissions and new orders will be reviewed during morning meeting and care plans revised as appropriate. Care plans will also be reviewed and revised as appropriate during the weekly high risk meetings.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.
Completion date: July 21, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B WING _____	06/22/2016

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 279	Continued From page 5	F 279		

comprehensive care plan for urinary incontinence for Resident #1 .

The surveyor reviewed Resident #1's clinical record 6/21/16. Resident #1 was admitted to the facility 8/5/15 and readmitted 1/12/16 with diagnoses that included but not limited to dementia without behavioral disturbances, transient cerebral ischemic attacks, Meniere's disease, hypertension, and gastroesophageal reflux disease.

Resident #1's admission minimum data set (MOS) assessment with an assessment reference date (ARD) of 8/12/15 assessed the resident with a cognitive summary score of 3 out of 15 in Section C Summary Score. Section V was reviewed and the following care areas were triggered with the decision to care plan these areas: cognition, visual, communication, urinary incontinence, behavioral symptoms, falls, nutrition, dental, and pressure ulcers.

The current comprehensive care plan initiated 8/18/15 and revised 6/15/16 did not reveal a care plan was developed for urinary incontinence.

The surveyor discussed the lack of a care plan for urinary incontinence with licensed practical nurse #1 on 6/21/16 at 4 :30 p.m. After reviewing the triggered areas in Section V and the current comprehensive care plan, L.P. N. #1 stated there was no care plan for urinary incontinence.

The surveyor informed the administrator, director of nursing, and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.

No further information was provided prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 279	Continued From page 6	F 279		

exit conference on 6/22/16.

2. The facility staff failed to develop a comprehensive care plan for mood for Resident #4.

The clinical record of Resident #4 was reviewed 6/22/16. Resident #4 was admitted to the facility 10/23/15 with diagnoses that included but not limited to abnormal posture, acute embolism and thrombosis of deep veins of lower extremities, and dementia without behavioral disturbances .

Resident #4's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/15 assessed the resident with a cognitive summary score of 3 out of 15 in Section C Summary Score. Section V Care Area Assessment Summary was reviewed. The following care areas were triggered with the decision to proceed to care plan the following : cognition, urinary incontinence, mood, falls, nutrition, and pressure ulcers.

The comprehensive care plan for Resident #4 was initiated on 12/3/15. The surveyor was unable to locate the care plan for mood. The surveyor requested the assistance of licensed practical nurse #1 on 6/22/16 at 4:05 p.m. to locate the care plan for mood for Resident #4 . L.P.N. #4 stated "It's not there. Resident #4 didn't trigger in that many areas."

The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 6/22/16 at 6:08 p.m.

No further information was provided prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 279	Continued From page 7	F 279		

exit conference on 6/22/16 .

3. The facility staff failed to develop a comprehensive care plan for psychotropic drug use for Resident #5.

The surveyor reviewed Resident #5's clinical record on 6/21/16 and 6/22/16. Resident #5 was admitted to the facility 4/30/09 and readmitted 1/6/13 with diagnoses that included but not limited to chronic airway obstruction, polyneuropathy in diabetes, neurogenic bladder with suprapubic catheter, iron deficiency anemia, diabetes mellitus, cellulitis, hypertension, hyperpotassemia, urinary tract infection, sacral ulcer, left gluteal fold ulcer, and fistula of intestine with colostomy.
Resident #5's annual minimum data set (MOS) assessment with an assessment reference date (ARD) of 2/23/16 assessed the cognitive status as 8 out of 15 in Section C Summary Score. Section V had the following care areas triggered and marked to proceed with care planning: cognition, AOL (activities of daily living), urinary incontinence, falls, nutrition, dental, pressure ulcer, and psychotropic drug use.
A review of the current comprehensive care plan with the most recent revision dated 3/15/16 did not reveal a care plan had been developed for psychotropic drug use. Resident #5 was currently receiving medications for depression (Sertraline and Remeron).
The surveyor interviewed licensed practical nurse #1 on 6/22/16 at 11:20 a.m. During the interview, the surveyor asked L.P.N. #1 to locate the care plan for psychotropic drug use. After reviewing the care plans, L.P.N. #1 stated there was not a care plan for psychotropic drugs. L.P.N. #1 stated the facility had tried to get Resident #5 *off*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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 279	Continued From page 8	F 279		

the medications but had not yet succeeded . She stated "The care plan's not there."
The surveyor informed the administrator, the director of nursing and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.
No further information was provided prior to the exit conference on 6/22/16.

4. For Resident #3, the facility staff failed to develop a comprehensive plan for mood and dehydration.

Resident #3 was admitted to the facility on 8/6/13 and readmitted on 5/3/16. His diagnoses included but were not limited to: diabetes, Parkinson ' s disease, septicemia, schizophrenia, anxiety and mild intellectual disabilities.

Resident #3 ' s significant change MOS (minimum data set) assessment, with an ARD (assessment reference date) of 5/10/16, was reviewed. The assessment scored the resident to be an 8 in section C for his cognitive pattern. In Section I Resident #3 was coded to have the diagnosis of schizophrenia and mild intellectual disabilities. In section V it showed both mood and dehydration triggered to go to the care plan.

Review of the current comprehensive plan with a 5/26/16 revision date did not reflect a care plan for mood or dehydration.

During an interview with the MOS nurse the surveyor asked her to find mood and dehydration in the comprehensive care plan. She reviewed section V for the triggered mood and dehydration and then reviewed the care plan. After her review she informed the surveyor; " We looked at it in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION OATE

F 279 Continued From page 9

care planning, but it is not there. "

At 3:07 pm, during a meeting with the administrator, director of nurses and the assistant director of nurses the failure to develop a comprehensive plan of care for Resident #3 in the area of mood and dehydration .

Prior to exit no further information was provided to the surveyor related to the comprehensive plan of care for Resident #3.

F 279

F 285 SS=E 483.20(m), 483 .20(e) PASRR REQUIREMENTS FOR MI & MR

A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483 , subpart C to the maximum extent practicable to avoid duplicative testing and effort.

A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority , prior to admission;
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section , unless the State mental retardation or developmental disability authority

F 285

Residents #1, #2, #3, #4, #5, #6, and #7 as identified were reviewed and a Pre-Admission Screening and Resident Review were completed for each during the survey.

A review of current residents was completed to ensure PASRR have been completed if required.

Interdisciplinary Team will be educated by the Director of Clinical Services/designee on the requirements for completion of the PASRR within 30 days of admission to the center and the criteria on which residents require the completion of the PASRR.

Prior to admission to the center the Social Services Director/designee will review potential admissions to ensure the PASRR has been completed if the resident meets the criteria for completion in a timely manner prior to admission to the center. In addition, new admissions will be reviewed in the morning meeting to ensure the PASRR has been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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 IDEN-rIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE

F 285 Continued From page 10

has determined prior to admission--

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

For purposes of this section :

(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483 . 102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to complete a Level 1 Pre-Admission Screening and Resident Review for 7 of 14 residents. (Resident # ' s 1, 2, 3, 4, 5, 6, and 7)

The findings included:

1. The facility staff failed to complete a Pre-Admission Screening and Resident Review for Resident #6 .

Resident #6 was readmitted to the facility on 10/10/15 with the following diagnoses of, but not limited to high blood pressure, stroke, anxiety disorder, aphasia and dementia . On the quarterly MOS (Minimum Data Set, an assessment tool) with an ARD (Assessment Reference Date) of 2/15/16 coded the resident as having long term and short term memory problems with being severely impaired in decision making. The

F 285 Continued From page 10

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

Completion date: July 21, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER :	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING _____	06/22/2016

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 285	Continued From page 11	F 285		

resident also requires total independence of2 staff members for bathing and hygiene.
During the clinical record review, the surveyor noted that a Pre-admission Screening and Resident Review (PASRR) was not completed within 30 days to the resident being admitted to the nursing facility.
In the end of the day meeting on 6/21/16 at approximately 4: 15 pm, with the administrator, director of nursing and the assistant director of nursing were notified of the above documented findings .
The director of nursing came to the surveyor on 6/22/16 and stated, " we went through all the residents ' charts and completed all of the PASRRs for all the residents last night. "
No further information was provided to the surveyor prior to the exit conference on 6/22/16 .

2. The facility staff failed to complete a Pre-Admission Screening and Resident Review for Resident #7.
Resident #7 was admitted to the facility on 11/11/15 with the following diagnoses of, but not limited to anemia, dementia and chronic kidney disease. On the quarterly MOS (Minimum Data Set, an assessment tool) with an ARD (Assessment Reference Date) of 5/17/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. The resident also requires extensive assistance of 2 staff members for bathing and hygiene.
During the clinical record review, the surveyor noted that a Pre-admission Screening and Resident Review (PASRR) was not completed within 30 days of the resident being admitted to the nursing facility .
In the end of the day meeting on 6/21/16 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 12	F 285		

approximately 4:15 pm, with the administrator, director of nursing and the assistant director of nursing were notified of the above documented findings.
The director of nursing came to the surveyor on 6/22/16 and stated, " we went through all the residents ' charts and completed all of the PASRRs for all the residents last night. "
No further information was provided to the surveyor prior to the exit conference on 6/22/16 .
3. For Resident #2, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed. The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). This is called a "Level I screen.
Resident #2 was admitted to the facility on 1/2/13. His diagnoses included but were not limited to: diabetes, Bipolar, edema, atrial fibrillation, stroke, hypertension, anxiety and depression.

Resident #2 ' s MDS (minimum data set) assessment, with an ARD (assessment reference date) of 3/10/16, was reviewed. The assessment scored the resident to be a 3 in section C for his cognitive pattern. In Section I Resident #2 was coded to have the diagnosis of bipolar disease.

A review of the Resident #2 clinical record failed to include a copy of the Level one screening for mental illness, mental retardation/intellectual disability, or related condition. The form is an assessment for mental illness

On 6/21/16 two surveyors asked the social worker if the form had been completed. She was also asked to show the surveyor where Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 13	F 285		

2 ' s form was . She said she was unaware one need to be done.

On 6/22/16 at 8:35 am, the social worker brought a Level 1 screening form for Resident #2 and said Ilooked on line and found the screening form. I have completed one on all the residents now.

At 3:07 pm, during a meeting with the administrator, director of nurses and the assistant director of nurses the failure to do the mental health screening for the residents was discussed.

Prior to exit no further information was provided to the surveyor related to the mental health screening assessment.

4. For Resident #3, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed . The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). This is called a Level I screen. Resident #3 was admitted to the facility on 8/6/13 and readmitted on 5/3/16 . His diagnoses included but were not limited to: diabetes, Parkinson ' s disease, septicemia, schizophrenia, anxiety and mild intellectual disabilities .

Resident #3 ' s MOS (minimum data set) assessment, with an ARD (assessment reference date) of 5/31/16, was reviewed. The assessment scored the resident to be an 8 in section C for his cognitive pattern. In Section I Resident #3 was coded to have the diagnosis of schizophrenia and mild intellectual disabilities .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B WING _____	06/22/2016

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

(X4) 1D 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)	(XS) COMPLETION DATE
F 285	Continued From page 14	F 285		

A review of the Resident #3 clinical record failed to include a copy of the Level one screening for mental illness, mental retardation/intellectual disability, or related condition. The form is an assessment for mental illness

On 6/21/16 two surveyors asked the social worker if the form had been completed. She was also asked to show the surveyor where Resident # 3 ' s form was. She said she was unaware one needed to be done.

On 6/22/16 at 8:35 am, the social worker brought a Level 1 screening form for Resident #3 and said I looked on line and found the screening form. " I have completed one on all the residents now. "

At 3:07 pm, during a meeting with the administrator, director of nurses and the assistant director of nurses the failure to do the mental health screening for the residents was discussed.

Prior to exit no further information was provided to the surveyor related to the mental health screening assessment.
5. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #1.
The Code of Virginia reads "§ 32.1-330. Preadmission screening required. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 15	F 285		

individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123 http://law.lis.virginia.gov/vacode/32 .1-123/>, are eligible for medical assistance or will become eligible within six months following admission . For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application."

The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). This is called a "Level I screen."

The surveyor reviewed Resident #1's clinical record 6/21/16. Resident #1 was admitted to the facility 8/5/15 and readmitted 1/12/16 with diagnoses that included but not limited to dementia without behavioral disturbances, transient cerebral ischemic attacks, Meniere's disease, hypertension, and gastroesophageal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 16	F 285		

reflux disease.

Resident #1's admission minimum data set (MOS) assessment with an assessment reference date (ARD) of 8/12/15 assessed the resident with a cognitive summary score of 3 out of 15 in Section C Summary Score.

During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #1.

The surveyor interviewed the social worker on 6/21/16 at 5:30 p.m. to locate the pre-admission screening form. The social worker stated Resident #1 didn't require one. The social worker stated the pre-admission screening form was only completed on residents with a mental illness or mental retardation or dually diagnosed.

In an interview with the social worker on 6/22/16 at 8:35 a.m., the social worker stated she had found the pre-admission form on line. The social worker stated the facility was only doing them on residents who were mentally retarded, those residents with mental illness and/or those dually diagnosed. The social worker stated the pre-admission screening form had been completed on Resident #1 6/21/16.

The surveyor informed the administrator, director of nursing, and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.

No further information was provided prior to the exit conference on 6/22/16.

6. The facility staff failed to complete a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 17	F 285		

preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #4.

The Code of Virginia reads "§ 32. 1-330. Preadmission screening required. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123 http://law .lis.virginia .gov/vacode/32 .1-123/>, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only . For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application ."

The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 18	F 285		

preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). This is called a "Level I screen."

The clinical record of Resident #4 was reviewed on 6/21/16 and 6/22/16 . Resident #4 was admitted to the facility 10/23/15 with diagnoses that included but not limited to abnormal posture, acute embolism and thrombosis of deep veins of lower extremities, and dementia without behavioral disturbances.

Resident #4's admission minimum data set (MOS) assessment with an assessment reference date (ARD) of 10/30/15 assessed the resident with a cognitive summary score of 3 out of 15 in Section C Summary Score.

During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #4.

The surveyor interviewed the social worker on 6/21/16 at 5:30 p.m. to locate the pre-admission screening form. The social worker stated Resident #4 didn't require one. The social worker stated the pre-admission screening form was only completed on residents with a mental illness or mental retardation or dually diagnosed.

In an interview with the social worker on 6/22/16 at 8:35 a.m., the social worker stated she had found the pre-admission form on line. The social worker stated the facility was only doing them on residents who were mentally retarded, those residents with mental illness and/or those dually diagnosed. The social worker stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 19	F 285		

pre-admission screening form had been completed on Resident #4 on 6/21/16.

The surveyor informed the administrator, director of nursing, and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.

No further information was provided prior to the exit conference on 6/22/16.

7. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #5.

The Code of Virginia reads "§ 32.1-330 . Preadmission screening required. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123 http://law.lis.virginia.gov/vacode/32.1-123/>, are eligible for medical assistance or will become eligible within six months following admission . For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B.WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 20	F 285		

Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application ."

The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). This is called a "Level I screen."

The surveyor reviewed Resident #S's clinical record on 6/21/16 and 6/22/16 . Resident #5 was admitted to the facility 4/30/09 and readmitted 1/6/13 with diagnoses that included but not limited to chronic airway obstruction, polyneuropathy in diabetes, neurogenic bladder with suprapubic catheter, iron deficiency anemia, diabetes mellitus, cellulitis, hypertension, hyperpotassemia, urinary tract infection, sacral ulcer, left gluteal fold ulcer, and fistula of intestine with colostomy.
Resident #S's annual minimum data set (MOS) assessment with an assessment reference date (ARD) of 2/23/16 assessed the cognitive status as 8 out of 15 in Section C Summary Score.
During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #5.

The surveyor interviewed the social worker on 6/21/16 at 5:30 p.m. to locate the pre-admission screening form. The social worker stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING _____	06/22/2016

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)	(XS) COMPLETION DATE
F 285	Continued From page 21	F 285		

Resident #5 didn't require one. The social worker stated the pre-admission screening form was only completed on residents with a mental illness or , mental retardation or dually diagnosed.

In an interview with the social worker on 6/22/16 at 8:35 a.m., the social worker stated she had found the pre-admiss ion form on line. The social worker stated the facility was only doing them on residents who were mentally retarded, those residents with mental illness and/or those dually diagnosed . The social worker stated the pre-admission screening form had been completed on Resident #5 on 6/21/16.

The surveyor informed the administrator , the director of nursing and the assistant director of nursing of the above finding on 6/22/16 at 3:08 p.m.
No further information was provided prior to the exit conference on 6/22/16.

State of Virainia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A BUILDING _____ B. WING	06/22/2016

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)	(XS) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 6/21/16 through 6/22/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 60 certified bed facility was 48 at the time of the survey . The survey sample consisted of 11 current Resident reviews (Residents 1 through 11) and 3 closed record reviews (Residents 12 through 14).

F 001 Non Compliance — F 001

State Tag: See F Tag # 279

July 21, 2016

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-250 Resident assessment and care planning
12 VAC 5-371-250 (F, G) Cross Reference to F-279.

Bob Nelson — Administrator — 7/13/16

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