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

PRINTED: 08/14/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	R 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid follow-up survey to the standard/complaint survey with dates of 05/31/18 through 06/04/18 was conducted on 7/24/18 through 7/26/18. Uncorrected deficiencies are identified within this report. The census in this 138 bed facility was 124 at the time of this survey. The survey sample consisted of 22 current record reviews.	{F 000}	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirements and the statements made on 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 or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
{F 557} SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to maintain dignity for 2 of 22 residents in the survey sample (Resident #4 and #23). The findings included: 1. The facility staff failed to maintain dignity of Revisit Resident #4 during the wound care observation. Revisit Resident #4 was admitted to the facility on 3/1/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart	{F 557}	1. Administrator met with both resident #4 and #23 to ensure there was no psychosocial harm associated with incident. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Certified Nursing Aide staff and Nursing staff to be re-educated on dignity. Care Keeper Rounds audit completed weekly x 8 weeks to include resident covered under dignity. Wound care audits to be completed 2x a week x 8 weeks to ensure facility staff maintain resident's dignity during wound care. Patient Interview & Observation (Dignity) questionnaire to be completed by Social Services Director and/or Designee 2x a week x 8 weeks to ensure facility staff maintain the dignity of residents in the facility. 4. Results of audits/rounds will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 08/21/2018

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

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{F 557}	Continued From page 1	{F 557}		

failure, high blood pressure, Peripheral Vascular Disease, End Stage Renal Disease, diabetes and depression. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/2/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Revisit Resident #4 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.

During the wound care observation on 7/25/18 at approximately 11:30 am, the surveyor observed LPN (licensed practical nurse) #2 perform the dressing change as ordered to the resident's right (R) hand and left stump. During both of these dressing changes LPN #2 applied the dressing, secured the dressing then with a magic marker dated and initial the dressings after it had been applied to the resident's right hand and left stump.

The surveyor interviewed LPN #2 after the above documented dressing changes and notified her that she had applied the dressings to both areas then dated and initialed both dressings after it had been applied to the resident. LPN #2 stated, "I got nervous and didn't realize that I had done that."

The surveyor notified the administrative team of the above documented findings on 7/25/18 at 5 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 7/26/18.

2. The facility staff failed to maintain dignity

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{F 557}	Continued From page 2 while transferring Revisit Resident #23 in a wheelchair from the resident's room to the dining room. Revisit Resident #23 was admitted to the facility on 5/19/16 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, Peripheral Vascular Disease, diabetes and stroke. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/4/18 coded the revisit resident of having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The Revisit Resident #23 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing. On 7/25/18 at 7:50 am, Revisit Resident #23 was being taken by wheelchair from her room to the dining room by CNA (certified nursing assistance) #1. The surveyor observed CNA #1 holding a sheet under her right arm while pushing the wheelchair. Both the upper and lower extremities of the resident was exposed when observed by the surveyor. CNA #1 placed the resident at the table for breakfast and then placed the sheet over the resident's legs. At 7:55 am, the surveyor asked the resident if not being covered up bothers her and the Resident stated, "No, I'm use to it. That will happen all the time so I don't get myself upset about it." At 8:05 am, the surveyor notified CNA (Certified Nurses' Assistant) #2 of the above observation made this morning. CNA #2 stated, "I didn't think about it. It was falling off her legs; I took it off and	{F 557}	RECEIVED AUG 22 2018 VDH/OLC	

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{F 557}	Continued From page 3 carried it with us to the dining room." At approximately 9 am, the surveyor notified the administrative team was notified of the above documented observation made on 7/25/18 at 7:50 am. The administrator stated, "Yes they should cover the resident so they are not exposed." No further information was provided to the surveyor prior to the exit conference on 7/26/18.	{F 557}		
{F 561} SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	{F 561}	1. Administrator spoke with resident # 22. Resident placed back on CNA's assignment. 2. Residents that reside in facility have the potential to be effected by this deficient practice. 3. Staff re-educated on resident rights including resident preferences. Resident interviews for preference to be completed by Social Services Director and/or Designee 2x a week x 8 weeks, to ensure facility staff promote and facilitate a resident's self-determination through support of resident's choice. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 561}	Continued From page 4 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review, the facility staff failed to promote and facilitate a resident's self-determination through support of resident choice for 1 of 22 residents in the survey sample (Revisit Resident #22). The findings included: Revisit Resident #22 was readmitted to the facility on 9/2/15 with the following diagnoses of, but not limited to high blood pressure, diabetes, seizure disorder, anxiety disorder, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/7/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Revisit Resident #22 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. During the initial tour of the Patio Unit on 7/24/18 at 2 pm, Revisit Resident #22 asked the surveyor about a concern she has had. The resident stated, "I want to know what I have done to make ______ (name of CNA; certified nursing assistant) not want to take care of me? I have been told that the male CNAs could not take care of the female residents. But I don't believe that because he has been taking care of me and my husband and then all of a sudden he quit taking care of me. He still comes into my room to take care of my husband. Could you find out why he	{F 561}		

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{F 561}	Continued From page 5	{F 561}		

can't take care of me too?" The surveyor noted that the resident became tearful while talking to the surveyor about the above documented conversation. The resident continued to state "I don't care for him having to help bath me or clean me up if I have an accident. I just want to find out why he can't care for me too."

The surveyor notified the administrative team on 7/26/18 at 9 am, of the above documented conversation with Revisit Resident #22. Another surveyor on the survey team also notified the administrative staff of the comments that had been voiced to her on 7/25/18 during the Resident Council meeting. The other surveyor stated that the resident had asked her why _____ (name of CNA) cannot take care of her anymore. The administrator stated, "_____ (name of Revisit Resident #22) has had a history of inappropriate remarks made to CNA so the decision was made to not have ______ (name of CNA) provide care to her. The surveyor asked the administrator, director of nursing and the unit manager for the Patio unit if anyone had spoken to the resident concerning this matter. The administrator stated, "I don't believe so." The unit manager for the Patio unit stated, "I will go and talk to ______ (name of Revisit Resident #22) about this concern."

At 11:45 am, the resident was out in the hallway going to the dining room for lunch. The resident thanked the surveyor for helping to get _____ (name of CNA) to take care of her again. The surveyor noted that the resident appeared very excited, clapping her hands saying, "I get to have _____ (name of CNA) back when he is working tomorrow. The resident was smiling and telling everyone that she passed in the hallway that she

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{F 561}	Continued From page 6 could not wait until tomorrow. No further information was provided to the surveyor prior to the exit conference on 7/26/18.	{F 561}		
{F 565} SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	{F 565}	1.Resident's grievances and concerns discussed during morning meeting and addressed in a timely manner. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Department Head Staff re-educated by the Vice President of Clinical Reimbursement regarding the proper way to complete Resident Concern Forms and follow up on Concern forms during Resident Council. Staff to ensure Concern Forms are available to all residents and staff members. Administrator to review Concern Form Deadline during morning meeting to ensure timeliness of Concern Form Process. Audits to be completed by Administrator and/or Designee monthly x 6 months to ensure facility staff responds to concerns expressed by resident council members. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 565}	Continued From page 7 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and resident council meeting minute review, the facility staff failed to respond to concerns and/or grievances expressed by the Resident Council members. The findings included: The facility staff failed to follow up on concerns expressed by resident council members and ensure that the resident council members were made aware of the resolutions. On 7/25/18 at 11:00 am, the surveyor conducted a resident council meeting with 4 alert and oriented members present. The surveyor asked the group if the facility considers their views and acts promptly and follows up with them if they express any concerns or grievances. Each member in the group stated "No." The surveyor reviewed the resident council meeting minutes with the group from the resident council meeting that was held on 7/11/18. The meeting minutes includes documentation that includes but is not limited to ... "5. Old Business: (A review of each issue brought up as NEW BUSINESS at the last meeting. Read the Department Response that was submitted to show the resolution of the issue. Ask for a show of hands of how many residents feel the department's resolution resolved the issue to their satisfaction, resubmit it to the appropriate department head. If the issue repeats again within 3 months, submit to the QAA	{F 565}		

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{F 565}	Continued From page 8 committee.) (quality assessment and assurance) A. (handwritten) No snacks at bedtime Was the issue resolved to your satisfaction? A handwritten check mark is documented beside NO. B. (handwritten) No ice given Was the issue resolved to your satisfaction? A handwritten check mark is documented beside NO. C. (handwritten)Food continues to be bad Was the issue resolved to your satisfaction? A handwritten check mark is documented beside NO. 6. New Business: (Any issues or concerns. For each concern raised, ask for a show of hands of those sharing the same concern. Record the concern and the number of residents who shared it. If only one resident has that concern, do not list as a council issue, but write a referral to the appropriate department. If two or more residents share the same concern proceed to the Department Response form). Some residents may chose not to vote if they feel the issue does not pertain to them. A. (handwritten) No snacks at bedtime Number of residents who share the same concern: (handwritten) 10 B. (handwritten) No ice given (Patio and North) Number of residents who share the same concern (handwritten) 8 C (handwritten) Food continues to be bad Number of residents that share the same concern (handwritten 10 D (handwritten) Missing clothes Number of residents that share the same concern (handwritten) 2"... The surveyor reviewed each of the issues as documented above with the resident council	{F 565}		

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{F 565}	Continued From page 9 members. When the surveyor asked if the facility was providing snacks at bedtime. A member expressed that the South wing does get snacks however, the other members expressed that they received little to no snacks at bedtime. The surveyor asked the group if they received ice. One group member responded that she received ice because she is able to take her cup and go to the chest and they will give her ice but then stated "but what about the ones who aren't able to." The surveyor asked the group if the food has gotten better. All members in the group stated "No." The surveyor asked the group if any staff member had discussed the concerns that have been voiced with them and provided any feedback. All members of the group stated "No." The facility staff completed a plan of correction with a completion date of 7/4/18. The plan of correction contains documentation that includes but is not limited to:"3. Staff members re-educated regarding completing concern forms within 5 days and resolution is discussed with resident and or resident representative." On 7/26/18 at 12:30 pm, the administrative team was made aware of the findings as stated above. The administrator provided the surveyor with 3 concern forms. The concern form regarding no ice being given on the north and patio wing dated 7/13/18 has a (X) handwritten next to "was the patient concern resolved?" The form also states describe the resolution. There is no documented description of the resolution on the form. The concern form regarding no snacks given at bedtime is dated 7/13/18 has a handwritten (X) next to "Was the patient concern resolved?" The form also states describe the resolution. There is no documented description of the resolution on	{F 565}		

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{F 565}	Continued From page 10 the form. The concern form regarding missing clothes is dated 7/13/18. Was the concern resolved is observed on the form however, there is no documentation on yes or no of the form. There is documentation that states "Found (Resident's name withheld) blue sweater never able to find red dress. (Resident's name withheld) was not able to describe the items she was missing." The surveyor was not provided a concern form about the food. The surveyor spoke with the administrator about the residents having the same concerns during the last two resident council meetings and also expressed many of the same concerns to the surveyor today. The surveyor spoke with the administrator about the residents concern about the food and the administrator stated, "They will always say the food is bad." The surveyor also spoke with the administrator about the discrepancy with the concern forms. The surveyor informed the administrator that even though she has provided the surveyor with these forms, the residents listed on the concern forms were in the meeting, expressed the same concerns, and reported to the surveyor that they have not received any follow-up. The administrator stated to the surveyor, "I understand." No further information was provided to the survey team prior to the exit conference on 7/26/18.	{F 565}		
{F 684} SS=E	Quality of Care CFR(s): 483.25 § 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	{F 684}		

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{F 684}	Continued From page 11 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to follow physician's orders for 1 of 23 resident's in the survey sample, Resident #15. The findings included: The facility staff failed to follow physician's orders to flush port-a-cath every 30 days for Revisit Resident #15. Revisit Resident #15 is a 63-year-old-male who was originally admitted to the facility on 4/10/13. Diagnoses include but are not limited to: schizophrenia, anemia, hypertension, and chronic ischemic heart disease. The most recent MDS (minimum data set) assessment for Revisit Resident #15 was a quarterly assessment with an ARD (assessment reference date) of 5/21/18. Section C assesses cognitive patterns. In Section C 0500, the facility staff documented that Revisit Resident #15 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicates that Revisit Resident # 15's cognitive status is severely impaired. The current plan of care for Revisit Resident #15 was reviewed and revised on 5/24/18. The facility staff documented a focus area for Revisit Resident #15 as "Infection actual or risk for related to: port-a-cath-left chest." Interventions include but are not limited to: "Flush port-a-cath	{F 684}	1. Resident #15's MD notified of failure to follow physician order. No new orders. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Re-educate Nursing staff regarding IV Protocol and the 5 Rights of Medication Administration. Audit to be completed by DON and/or Designee of medication administration records 3 x week x 8 weeks weeks to ensure facility staff administer medications per Physician Orders. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 684}	Continued From page 12	{F 684}		

per order-observe for s/sx (signs and symptoms) of infection/problems-inform MD (medical doctor) PRN (as needed)."

The physician signed the current orders for Revisit Resident #15 on 7/13/18. Orders include but are not limited to: "Heparin Lock Flush Solution 10 unit/ml (milliliter) Use 5 ml intravenously in the morning every 30 day (s) related to other forms of angina pectoris heparin lock flush with heparin 5 ml one time every 30 days for port-a-cath. If cath to lt (left) chest is not able to be accessed flush with 20 ml normal saline then flush with heparin 5ml. ONLY TO BE DONE BY RN (registered nurse)."

The facility submitted a plan of correction with a completion date of 7/4/18. The plan of correction has documentation that includes but is not limited to: Revisit Resident #15 "had port-a-cath flushed on 6/5/18, no issues. MD aware with no new orders." "3. Staff re-educated by DON (director of nursing) and human resources regarding maintaining the highest practical well being of the residents in the facility. Physician Order Sheet Audit to be completed by DON and/or designee regarding medication administration 5 x (times) a week x 8 weeks to ensure facility staff administer medications per physician's order."

On 7/24/18 at 2:32 pm, the surveyor reviewed the clinical record for Revist Resident #15. Upon review on the electronic medication administration record and the progress notes since 7/4/18, there was no documentation that the facility staff had flushed the port-a-cath for Revisit Resident #15. The surveyor did observe an empty block on the electronic medication administration record for 7/2/18 at 9:00 am next

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{F 684} Continued From page 13
to the heparin Lock flush order.

On 7/24/18 at 4:24 pm, the surveyor asked the facility staff to provide her with a copy of the July 2018 medication administration record and progress notes since 7/4/18 for Revisit Resident #15.

On 7/24/18 at 5:10 pm, the surveyor went to the DON's office and was provided with a copy of the July 2018 medication administration record for Resident # R15. The surveyor observed documentation on the medication administration record for the heparin lock flush on 7/2/18 at 9:00 am that was not there previously. The surveyor spoke with the DON and informed her that the signature that was now on the medication administration record for the heparin lock flush on 7/2/18 at 9:00 am was not there previously. The DON stated, "Well I did it, I'm the only one that does them." The surveyor then asked the DON when she documented that she did it because the documentation was not there previously. The DON stated, "A little while ago." The medication administration audit report reflected that the DON documented for the Heparin Lock flush on 7/2/18 at 9:00 am on 7/24/18 at 4:51 pm.

On 7/25/18 at 5:15 pm, the administrative team was made aware of the findings as stated above. The surveyor spoke with the administrative team and reviewed the heparin lock flush order that was to be administered every 30 days. The surveyor reviewed that the plan of correction documented that the port-a-cath was last flushed on 6/5/18, therefore the next port-a-cath flush date should be 7/5/18, which is 30 days following the 6/5/18 date that the facility documented that Revisit Resident #15's port-a-cath was last

{F 684}

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{F 684}	Continued From page 14 flushed. The surveyor requested the facility provide any documentation of order changes regarding the port-a-cath flush. The surveyor did not locate any while reviewing the clinical record. On 7/26/18 at 3:36 pm, the facility consultant nurse informed the surveyor that she did not locate any changes in the port-a-cath orders for Resident # R15. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/26/18.	{F 684}		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to store a nebulizer mask in a plastic bag when not in use and failed to clean the filter of an oxygen concentrator for 2 of 22 residents (Revisit Resident #18 and #2). The findings included: 1. The facility staff failed to store a nebulizer mask in a plastic bag when not in use for Revisit	F 695	1. Resident #18's nebulizer tubing covered and bagged immediately. Resident #2's oxygen concentrator filter cleaned immediately. 2. Residents with orders for nebulizer treatments or oxygen have the potential to be effected by this deficient practice. 3. Staff members re-educated on Oxygen/ Nebulizer protocol. Care Keeper Rounds Audits to be completed by Department Heads weekly x 8 weeks to include oxygen/nebulizers are bagged and dated to ensure resident's nebulizer tubing is covered and oxygen concentrator filters are cleaned. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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F 695	Continued From page 15 Resident #18. Revisit Resident #18 was readmitted to the facility on 6/29/17 with diagnoses of, but not limited to high blood pressure, diabetes, dementia, anxiety disorder, depression, Chronic Obstructive Pulmonary Disease and respiratory failure. On the quarterly MDS with an ARD (Assessment Reference Date) of 6/13/18, the resident was coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. Revisit Resident#18 was also coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. On the initial tour of the facility on 7/24/18 at 1:42 pm, the surveyor observed the nebulizer mask sitting on the bedside table and was not stored in a plastic bag for Revisit Resident #18. At 2:45 pm, the surveyor again observed the nebulizer mask continued to be sitting on the bedside table and was not stored in a plastic bag. The surveyor asked LPN (Licensed Practical Nurse) #1 to accompany her to Revisit Resident #18's room. LPN #1 stated, "That mask needs to be stored in a plastic bag instead of sitting on the table like that. I will go and get a bag to place this in." The surveyor notified the administrative team of the above findings on 7/25/18 at 5 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 7/26/18. 2. The facility staff failed to ensure Revisit	F 695		

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Resident #2's oxygen filter was clean.

The clinical record of Revisit Resident #2's was reviewed 7/24/18 and 7/25/18. Revisit Resident #2 was admitted to the facility 1/7/2013 with diagnoses that included but not limited to respiratory failure, acute upper respiratory infection, chronic pain, pneumonia, lichen sclerosus, idiopathic peripheral autonomic neuropathy, diarrhea, hyponatremia, hypokalemia, ancd acute cholecystitis.

Revisit Resident #2's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/22/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15/15.

Revisit Resident #2's current comprehensive careplan was reviewed 7/24/18 and 7/25/18. One focus area read "Alteration in respiratory status due to chronic obstructive pulmonary disease, heart failure, h/o (history of) upper respiratory illness, h/o pneumonia. Interventions: Administer oxygen per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Implement infection control policies and procedures for specific disease."

The surveyor observed Revisit Resident #2 during the initial tour on 7/24/18 at 1:30 p.m. Revist Resident #2 was in bed, eyes closed. Oxygen concentrator was positioned on 3 and ½ liters. The filter, located at the back of the oxygen concentrator, had an accumulation of white debris on the charcoal colored filter.

The surveyor observed Revisit Resident #2 again

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on 7/24/18 at 4:51 p.m. The filter still had an accumulation of white debris.

The surveyor observed and interviewed Revisit Resident #2 again on 7/25/18 at 11:02 a.m. The oxygen filter was observed and the white debris remained. Revisit Resident #2 stated she knew the staff changed the tubing but she didn't know about cleaning the filter. Revisit Resident #2 stated she was able to adjust the liter amount on the machine.

The surveyor observed Revisit Resident #2 on 7/25/18 at 1:47 p.m. The surveyor asked licensed practical nurse #1 to look at the air filter on the back of Revisit Resident #2's oxygen concentrator. L.P.N. #2 stated the filter was dirty and proceeded to take it out, wash it, and then put the filter back in the machine. L.P.N. #1 stated the tubing was changed every week on night shift on Sunday but wasn't sure if the filters were cleaned then as well.

The surveyor requested the facility policy on oxygen administration from the corporate nurse on 7/25/18 at 3:00 p.m.

The July 2018 physician orders read "Change/date oxygen tubing and water bottle. Clean concentrator filter by rinsing with warm water and pat dry before replacing. Every night shift every Sun (Sunday)."

The July 2018 medication administration record was reviewed. The above entry for cleaning the concentrator had been entered and initialed 7/8/18, 7/15/18, and 7/22/18. Initials indicated treatments had been completed.

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F 695	Continued From page 18 The corporate registered nurse provided the surveyor the facility guidelines for oxygen administration and a checklist on 7/25/18 at 3:58 p.m. The oxygen checklist included the resident's name, room number, physician order, pulse ox order, flow rate documented in TAR/MAR (treatment administration record/medication administration record), oxygen in use sign, filter clean, tubing dated and changed weekly, tubing bagged/stored appropriately when not in use, care plan, and kardex. The coproate RN pointed to the surveyor cleaning the filter was part of the oxygen checklist. No further information was provided prior to the exit on 7/26/18.	F 695		
{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	{F 758}	1. Depakote added to resident # 7's behavior monitoring immediately. 2. Residents receiving psychotropic medications have the potential to be effected by this deficient practice. 3. Re-educated nursing staff regarding unnecessary psychotropic medications and behavior monitoring. IDT Team to review residents receiving psychotropic medications one category a week/all categories monthly in Chemical Restraint meeting weekly x 8 weeks to review for appropriate behaviors, interventions and gradual dose reductions. Audit to be conducted by Director of Nursing and/or designee weekly x 8 weeks to ensure residents are free from unnecessary medications. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 758}	Continued From page 19 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 22 residents was free of an unnecessary medication (Revisit Resident #7). The findings included: The faciity staff failed to monitor Depakote used for behaviors for Revisit Resident #7.	{F 758}		

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{F 758}	Continued From page 20 The clinical record of Revisit Resident #7 was reviewed on 7/24/18 and 7/25/18. Revisit Resident #7 was admitted to the facility 12/28/11 with diagnoses that included but not limited to Alzheimer's disease, atherosclerotic heart disease, osteoarthritis, type 2 diabetes mellitus, abnormal weight loss, iron deficiency anemia, urinary tract infection (UTI), hypothyroidism, peripheral vascular disease, vascular dementia without behavioral disturbances, major depressive disorder, anxiety, and hypochondriasis. Revisit Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/18/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 15/15. No delirium or psychosis assessed. Revisit Resident #7 did reject care 1-3 days. The July 2018 physician's order sheet was reviewed. Revisit Resident #7 had orders for Depakote Sprinkles Delayed Release 125 mg (milligrams) two times a day for behaviors. The current comprehensive care plan initiated 2/27/17 identified that the resident had behaviors which include being verbally abusive, socially inappropriate and frequent crying. Arguing with roommate and refusing to change rooms. Interventions: Attempt interventions before my behaviors begin, do not seat me around others who disturb me, give me my medications as my doctor has ordered, help me maintain my favorite place to sit, help me to avoid situations or people that are upsetting to me, let my physician know if my behaviors are interfering with my daily living, make sure I am not in pain or uncomfortable,	{F 758}		

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{F 758}	Continued From page 21 offer me something I like as a diversion, refer me to my psychologist/psychiatrist as needed, tell me what you are going to do before you begin. The surveyor reviewed the July 2018 medication administration record. Depakote sprinkles 125 mg two times a day had been administered from 7/4/18 through 7/25/18; however, upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, the surveyor could not locate monitoring of target behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Depakote. The surveyor informed the administrator on 7/25/18 at 4:04 p.m. The administrator stated Depakote was probably seen as just an anti-seizure medication-not as a psychotropic medication. No further information was provided prior to the exit conference on 7/26/18.	{F 758}		
{F 761} SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	{F 761}		

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{F 761}	Continued From page 22 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to ensure that medications were properly labeled when opened, discarded when expired, and stored at appropriate temperatures and in sanitary conditions in 2 of 3 medication storage rooms and 2 of 5 medication carts. On 7/25/18 at 2 PM, the surveyor checked the medication carts on the North unit. The cart was locked. The surveyor found a bottle of fluticasone propionate with factory-stamped expiration date 1/20/20 which was opened and appeared to have been used. The nurse (LPN#1) with the surveyor looked at the bottle and said it appeared to be about half empty and had probably been opened 7/9/18. LPN #1 labeled the bottle and stated that it would be good for a month after opening. In the same storage drawer, the surveyor found a bottle of phenylephrine hydrochloride nasal spray with factory stamped expiration date 8/19/19. The date 3/22/18 was written on the back of the bottle and 4/29/18 was written on the front. LPN#1 stated that opening dates would have been	{F 761}	1. Ayr Nasal spray discarded and new Ayr Nasal spray placed in cart with name and date labeled immediately. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing Staff re-educated regarding proper labeling and storage of medications in accordance with currently accepted professional principles. Audit to be conducted by Unit Managers and/or Designee of Unit medication carts and medication rooms to ensure the proper labeling of medications when opened, discarded when when expired, and stored at appropriate temperatures and in sanitary conditions in medication rooms and medication carts. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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(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 761}	Continued From page 23 written on the bottle. The medication would be discarded 30 days after opening. The North unit medication storage refrigerator held an open vial of flucelvax influenza vaccine with a factory stamped expiration date 5/18. There was no open date written on the vial. An open vial of tuberculin purified protein derivative was dated opened 7/6/17. The factory stamped expiration date was 7/18. A thin layer of ice covered or partly covered some items in a basket of insulin pens on the top shelf under the freezer. The bags containing medication for individual residents were easily freed from the ice. The freezer was covered with approximately a 1 inch layer of frost. When the surveyor checked inside the freezer, she found a frozen microwaveable meal. The concerns were reported to the director of nursing at approximately 2:30 PM on 7/25/18 and later discussed with the administrator during an end of day summary meeting. The facility's plan of correction for the deficiency cited in the standard survey with assertion of compliance date 7/4/18 stated that staff would audit medications 5 times per week. At the meeting, the surveyor asked for documentation of the medication cart checks from the facility's plan of correction. The documents indicated that the medication carts had been checked 5 times per week since the assertion of compliance. 2. The facility staff failed to ensure expired medications were removed from the medication cart for Revisit Resident #10. The surveyor reviewed the medication cart on the south unit with licensed practical nurse #2 on 7/24/18 at 2:05 p.m. In the top drawer, the	{F 761}		

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{F 761}	Continued From page 24	{F 761}		

surveyor observed a box with a vial of Novolog U100 insulin labeled for Revisit Resident #10. On the box was a date when opened (6/24/18) and a date when expired. The date for expired was 7/22/18. The surveyor asked L.P.N. #2 what was the process for expired medications. L.P.N. #2 stated the medication should be discarded and stated the medication would go into the sharps container. L.P.N. #2 stated Novolog should be discarded after 28 days. The vial of Novolog insulin was 2 days past the "use by date."

The surveyor reviewed Revisit Resident #10's clinic record on 7/24/18 and 7/25/18. Revisit Resident #10 was admitted to the facility 9/28/15 and readmitted 6/8/18 with diagnoses that included but not limited to peripheral vascular disease, hypocalcemia, insomnia, hepatic failure, Vitamin D deficiency, chronic diastolic heart failure, pressure ulcer left heel, exotropia, type 2 diabetes mellitus, chronic respiratory failure with hypoxia, and chronic kidney disease.

Revisit Resident #10's significant change is minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/13/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15/15.

The July 2018 physician's orders were reviewed. Physician's orders included Novolog Solution 100 unit/ml (milliliter) per sliding scale: If 0-200=0 units , < (less than) 60 call MD (medical doctor); 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; > 500, Call MD, subcutaneously two times a day related to Type 2 Diabetes Mellitus without complications.

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{F 761}	Continued From page 25	{F 761}		

The July 2018 medication administration record (MAR) was reviewed. Revisit Resident #10 received 4 units of Novolog on 7/23/18 at 2100 (9:00 p.m.) after the Novolog had expired.

The surveyor requested the facility policy on labeling and dating medications. The policy titled "Medications and Medication Labels" read in part "Multi-dose vials shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial)."

Novolog was accessed at www.drugs.com and had the following information about the storage of Novolog. Keep this medicine in its original container protected from heat and light. Do not draw insulin from a vial into a syringe until you are ready to give an injection. Do not freeze insulin or store it near the cooling element in a refrigerator. Throw away any insulin that has been frozen.

Storing unopened (not in use) NovoLog:
Refrigerate and use until expiration date; or
Store at room temperature and use within 28 days.

Storing opened (in use) NovoLog:
Store the vial in a refrigerator or at room temperature and use within 28 days.
Store the cartridge or injection pen at room temperature (do not refrigerate) and use within 28 days. Do not store the injection pen with a needle attached.
Do not use the medicine if it has changed colors or looks cloudy. Call your pharmacist for new medicine.

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{F 761}	Continued From page 26 The surveyor informed the administraor and the corporate registered nurse of the above issue in the end of the day meeting on 7/25/18 at 5:10 p.m. No further information was provided pror to the exit conference on 7/26/18. 3. The facility staff failed to label and date Revisit Resident #2's nasal medication Ayr. The surveyor reviewed the medication cart on the south unit with licensed practical nurse #2 on 7/24/18 at 2:05 p.m. In the top drawer, the surveyor observed a box of saline nasal gel labeled Ayr. The box did not have a resident name or a date when the saline gel had been opened. L.P.N. #2 stated Revisit Resident #2 had orders for Ayr but stated the order was for prn (if needed). L.P.N. #2 stated "I'm sure it should have a name on it. I think it's Revisit Resident #2's medication. She has a prn order for it." The clinical record of Revisit Resident #2's was reviewed 7/24/18 and 7/25/18. Revisit Resident #2 was admitted to the facility 1/7/2013 with diagnoses that included but not limited to 4:51 p.m.respiratory failure, acute upper respiratory infection, chronic pain, pneumonia, lichen sclerosus, midiopathic peripheral autonomic neuropathy, diarrhea, hyponatremia, hypokalemia, ancd acute cholecystitis. Revisit Resident #2's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/22/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15/15.	{F 761}		

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{F 761}	Continued From page 27 A review of Revisit Resident #2's July 2018 included an order for Ayr Saline Nasal Gel 1 application in both nostrils two times a day related to allergic rhinitis cause unspecified (order date 01/09/2015). The surveyor requested the facility policy on dating and labeling medications from the corporate registered nurse on 7/25/18 at 3:58 p.m. The policy titled "Medications and Medication Labels" read in part "h. Expiration or end-of -use date, if not dispensed in original manufacturer packaging." The surveyor informed the administrator and the corporate registered nurse of the above concern during the end of the day meeting on 7/25/18 at 5:10 p.m. No further information was made available prior to the exit conference on 7/26/18.	{F 761}		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(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 practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for	F 773	1. Resident # 10's MD notified of missed lab. No new orders. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Staff re-educated regarding lab protocol. Audit to be conducted of labs ordered for accuracy 2 x week x 8 weeks to ensure staff obtain physician ordered laboratory tests. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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notification of a practitioner or per the ordering physician's orders.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 1 of 22 residents (Revisit Resident #10).

The findings included:

The facility staff failed to obtain a CBC (complete blood count) ordered to be done 7/12/18 and failed to obtain a BMP (basic metabolic panel) ordered on 7/11/18 to be done on the next laboratory day.

The surveyor reviewed Revisit Resident #10's clinical record on 7/24/18 and 7/25/18. Revisit Resident #10 was admitted to the facility 9/28/15 and readmitted 6/8/18 with diagnoses that included but not limited to peripheral vascular disease, hypocalcemia, insomnia, hepatic failure, Vitamin D deficiency, chronic diastolic heart failure, pressure ulcer left heel, exotropia, type 2 diabetes mellitus, chronic respiratory failure with hypoxia, and chronic kidney disease.

Revisit Resident #10's significant change is minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/13/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15/15.

The clinical record was reviewed. Revisit Resident #10 had an order dated 7/11/18 that read "Lactulose 30 grams po (by mouth) qd (every day) and BMP (basic metaboloc

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F 773	Continued From page 29 panel)/ammonia level next lab day." The laboratory section of the clinical record was reviewed. The surveyor located the results of a CMP (comprehensive metabolic panel)-not a BMP as ordered. The surveyor informed the corporate registered nurse of the concern on 7/25/18 at 3:30 p.m. A second physician order read "Renal panel and CBC (complete blood count) 7/12/18." The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results. The surveyor informed the corporate registered nurse of the concern on 7/25/18 at 3:30 p.m. The corporate registered nurse informed the surveyor on 7/26/18 at 3:34 p.m. that the CBC was never obtained due to transcription error and a CMP was completed instead which contained the BMP. The medical doctor was informed and gave no new orders. No further information was provided prior to the exit conference on 7/26/18.	F 773		
{F 842} SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	{F 842}	1. Resident # 15's MD notified of omission of MAR documentation. No new orders. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing staff re-educated regarding IV Protocol and the 5 Rights of Medication Administration. Audit medication administration and of residents with IV access to be completed by Unit Managers and/or Designee weekly 2 x a week x 8 weeks to ensure the facility accurately maintains medical records. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 842}	Continued From page 30 §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	{F 842}		

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(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services 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 ensure an accurate clinical record for 1 of 23 Residents in the survey sample, Revisit Resident #15.

The findings included:

RevisitResident #R15.

Revisit Resident #15 is a 63-year-old-male who was originally admitted to the facility on 4/10/13. Diagnoses include but are not limited to: schizophrenia, anemia, hypertension, and chronic ischemic heart disease.

The most recent MDS (minimum data set) assessment for Revisit Resident #15 was a quarterly assessment with an ARD (assessment reference date) of 5/21/18. Section C assesses cognitive patterns. In Section C 0500, the facility staff documented that Revisit Resident #15 had a BIMS (brief interview for mental status) score of 5

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{F 842}	Continued From page 32 out of 15, which indicates that Revisit Resident #15's cognitive status is severely impaired. The current plan of care for Revisit Resident #15 was reviewed and revised on 5/24/18. The facility staff documented a focus area for Revisit Resident #15 as "Infection actual or risk for related to: port-a-cath-left chest." Interventions include but are not limited to: "Flush port-a-cath per order-observe for s/sx (signs and symptoms) of infection/problems-inform MD (medical doctor) PRN (as needed)." The physician signed the current orders for Revisit Resident #15 on 7/13/18. Orders include but are not limited to: "Heparin Lock Flush Solution 10 unit/ml (milliliter) Use 5 ml intravenously in the morning every 30 day (s) related to other forms of angina pectoris heparin lock flush with heparin 5 ml one time every 30 days for port-a-cath. If cath to lt (left) chest is not able to be accessed flush with 20 ml normal sailine then flush with heparin 5ml. ONLY TO BE DONE BY RN (registered nurse)." The facility submitted a plan of correction with a completion date of 7/4/18. The plan of correction contains documentation that includes but is not limited to: Revisit Resident #15 "had port-a-cath flushed on 6/5/18, no issues. MD aware with no new orders." "3. Staff re-educated by DON (director of nursing) and human resources regarding maintaining the highest practical well being of the residents in the facility. Physician Order Sheet Audit to be completed by DON and/or designee regarding medication administration 5 x (times) a week x 8 weeks to ensure facility staff administer medications per physician's order."	{F 842}		

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On 7/24/18 at 2:32 pm, the surveyor reviewed the clinical record for Resident #R15. Upon review on the electronic medication administration record and the progress notes since 7/4/18, there was no documentation that the facility staff had flushed the port-a-cath for Revisit Resident #15. The surveyor did observe an empty block on the electronic medication administration record for 7/2/18 at 9:00 am next to the heparin Lock flush order.

On 7/24/18 at 4:24 pm, the surveyor asked the facility staff to provide her with a copy of the July 2018 medication administration record and progress notes since 7/4/18 for Revisit Resident #15.

On 7/24/18 at 5:10 pm, the surveyor went to the DON's office and was provided with a copy of the July 2018 medication administration record for Revisit Resident #15. The surveyor observed documentation on the medication administration record for the heparin lock flush on 7/2/18 at 9:00 am that was not there previously. The surveyor spoke with the DON and informed her that the signature that was now on the medication administration record for the heparin lock flush on 7/2/18 at 9:00 am was not there previously. The DON stated, "Well I did it, I'm the only one that does them." The surveyor then asked the DON when she documented that she did it because the documentation was not there previously. The DON stated, "A little while ago." The medication administration audit report reflected that the DON documented for the Heparin Lock flush on 7/2/18 at 9:00 am on 7/24/18 at 4:51 pm.

According to the facility policy on "Medication

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{F 842}	Continued From page 34 Administration" there is information that includes but is not limited to ...."Documentation 1. The individual who administers the medication dose, records the administration on the resident's MAR (medication administration record) immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications." ... On 7/25/18 at 5:15 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/26/18	{F 842}		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, observations and clinical record review, the facility staff failed to ensure the quality assurance program meet the needs of the facility as evidenced by repeated deficiencies in the areas of resident rights, comprehensive resident centered care plan, quality of care, pharmacy services, administration and physical environment and failed to monitor the effects of implemented changes and make needed revisions to the action plans as needed	F 867	1. QAPI/QAA Process Immediately reviewed with Department Head Team. 2. Residents that reside in the facility have the potential to be effected. 3. Chief Clinical Officer to review monthly QAPI process x 3 months. QAPI Committee will review of Plan of Correction deficiencies once a week x 8 weeks. Weekly QA Audit to be completed by Administrator and Department Heads to review deficiencies of POC to ensure the quality assurance program meets the needs of the facility. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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for the prevention of further deficiencies, as evidenced by new findings (deficient practice) in the area of quality of care, laboratory, radiological and other diagnostic services and quality assurance and performance improvement.

The findings included:

On 7/24/18 at 1:00 pm, the survey team entered the facility for an abbreviated (revisit #1) survey.

During the course of the survey process, the surveyors identified deficient practice in the areas of resident rights, comprehensive resident centered care plan, quality of care, pharmacy services, administration and physical environment that were identified on the annual/complaint survey completed 5/31-6/4/18 and identified new findings of deficient practice in the area of quality of care, laboratory, radiological and other diagnostic services and quality assurance and performance improvement.

The survey team reviewed each deficient practice from the previous annual/complaint survey with the administrative team on 7/26/18 at approximately 10:30 am in the conference room. The surveyors also reviewed all supporting documentation, which stated that all of the deficient practices would be corrected with the date of completion being 7/4/18. The administrator stated to the survey team, "I know this doesn't show all of the work that went into correcting these deficient areas. We will have to go back and review and revise what is working and what isn't working so that we can correct all of these areas."

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
	495143	A. BUILDING ______ B. WING ______	R 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 36 surveyor prior to the exit conference on 7/26/18.	F 867		
{F 921} SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a clean, comfortable, sanitary environment for 1 of 22 residents in the survey sample (Revisit Resident #20) and on the North wing hallway of the facility. The findings included: 1. The facility staff failed to ensure Revisit Resident #20's room was clean, comfortable and sanitary. The clinical record of Revisit Resident #20 was reviewed 7/24/18 and 7/25/18. Revisit Resident #20 was admitted to the facility 11/3/17 and readmitted 2/14/18. Diagnoses included but were not limited to chronic obstructive pulmonary disease, aphasia, iron deficiency anemia, clotting factor deficiency, elevated white blood cell count, anxiety, severe protein-calorie malnutrition, chronic embolism and thrombosis of left upper extremity, enterocolitis due to Clostridium difficile, major depressive disorder, gastroesophageal reflux disease, hypertension, edema, and bipolar disorder. Revisit Resident #20's quarterly minimum data	{F 921}	1. Housekeeping cleaned Resident # 20's and North Wing Hall immediately to ensure there was no odor. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Housekeeping staff re-educated on the proper procedures for cleaning resident's rooms and hallways. Rounds to be conducted weekly x 8 weeks with Housekeeping District Manager and/or designee and Administrator and/or designee throughout the facility ensure a safe, clean, homelike environment. 4. Results of audits will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	08/24/2018

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{F 921}	Continued From page 37 set (MDS) assessment with an assessment reference date (ARD) of 6/20/18 assessed the resident with a BIMS (brief interview for mental status) as 6/15. Section H Bladder and Bowel assessed the resident as always incontinent of bladder and bowel. The surveyor observed Revisit Resident #20's room during the initial tour on 7/24/18 at 1:30 p.m. The door was closed when the surveyor first entered the room. Upon entering the room, the surveyor smelled a pervasive odor of urine in the room. The surveyor observed Revisit Resident #20's room on 7/25/18 at 10:46 a.m. The room had an odor of urine plus an odor of bowel. The surveyor and the housekeeping director observed the room on 7/25/18 at 10:50 a.m. The housekeeping director checked the closets, the corners of the rooms and the bathrooms and stated, "It was a body odor"-not from the room not being clean. The housekeeping director stated rooms are deep cleaned monthly. The surveyor asked when Revisit Resident #20's was last deep cleaned. The housekeeping director provided the surveyor with the "July 2018 Carbolization Schedule". Revisit Resident #20's room was scheduled to be deep cleaned on 7/20/18. The housekeeping director stated he was not at the facility on 7/20/18 and was not sure if the deep cleaning had been done. The surveyor requested the facility policy for cleaning resident rooms. The surveyor reviewed the facility daily patient room cleaning job and bathroom cleaning job provided by the housekeeping director. Steps to do the daily patient room cleaning: empty trash, horizontal dusting, spot clean, dust mop floor, and	{F 921}		

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{F 921}	Continued From page 38 damp mop floor. Steps to do bathroom cleaning: pull trash, fill dispensers, dust mop, sanitize sinks, light, mirror, sink, fixtures, pipes, sanitize commode, tank, bowl, base, spot clean walls, partitions, light switches, and damp mop. The surveyor informed the administrator and the corporate registered nurse of the above concern with Revisit Resident #20's room during the end of the day meeting on 7/25/18 at 5:10 p.m. The corporate registered nurse stated the facility does "carekeeper rounds". No further information was provided prior to the exit conference on 7/26/18. 2. The facility staff failed to ensure a clean, comfortable and homelike environment on the North wing hallway of the facility. This hallway had a pervasive odor of urine between rooms 111 to 116. On 7/25/18 at approximately 10 am, the surveyor noted a pervasive odor of urine on the North wing hallway, which included resident rooms 111 through 116. On 7/25/18 at 3:30 pm, the surveyor noted a pervasive odor of urine on the North wing hallway of the facility, which included resident rooms 111 through 116. On 7/26/18 at 9:30 am, the surveyor noted a pervasive odor of urine on the North wing hallway of facility, which included resident rooms 111 through 116. The surveyor notified the administrative team of the North wing hallway, which included resident rooms 111 through 116, of having a pervasive	{F 921}		

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{F 921}	Continued From page 39 odor of urine. This notification was made on 7/26/18 at 10:15 am. No further information was provided to the surveyor prior to the exit conference on 7/26/18.	{F 921}		

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