Mountain View
Regional Medical Center
A Member of Wellmont Health System

June 3, 2016

Mr. Rodney L. Miller
LTC Supervisor
Division of Long Term Care
Office of Licensure and Certification
9960 Mayland Drive-Suite 401
Henrico, Virginia 23233-1485

RE: POC for Mountain View Regional Medical Center, Norton, VA

Mr. Miller,

Please find our attached plan of action for our unannounced standard survey on May 11, 2016 for our Long Term Care Department.

If you have any questions, please feel free to contact me.

Regards,

Renau Hazlewood

Renau Hazlewood, BS, RN
Director of Risk/Quality
Lonesome Pine/Mountain View Regional Medical Center

310 Third Street, NE
Norton, Virginia 24273
276.679.9100
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. BUILDING _____ B. WING _____	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	310 THIRD STREET, NE NORTON, VA 24273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/10/16 through 5/11/16. 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 44 certified bed facility was 36 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Resident #1 through Resident #9) and 3 closed record reviews (Resident #10, Resident #11 and Resident #12).	F 000		
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.	F 155	Charge nurse will review 100% of Do Not Resusitate orders to verify accuracy and completion of Durable DNR. Charge nurse will then initial and date the back of the DNR verifying completion and accuracy of DNR in its entirety upon admission and with any new order for DNR. Numerator=number of completed DNRs Denominator=Number of DNR Orders	6/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Stanley – Dir. Quality/Risk | TITLE | (X6) DATE: 6-3-16

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 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR) for 1 of 12 Residents in the sample survey, Resident #5.
The Findings Included:
For Resident #5 the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR).
Resident #5 was an 82 year old female who was originally admitted on 8/19/14 and readmitted on 5/13/15. Admitting diagnoses included, but were not limited to: septicemia, depression, hypotension, bacterial pneumonia, acute and chronic respiratory failure, osteoporosis, diabetes mellitus, hypertension, congestive heart failure and emphysema.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #5 required limited (2/2) to extensive assistance (3/3) with Activities of Daily Living (ADL's).
On May 10, 2016 at 3:30 p.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 9/8/14. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident #5 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

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Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

On May 10, 2016 at 3:55 p.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #5's DDNR was incorrect/inaccurate. The surveyor reviewed the clinical record with the UM. The surveyor reviewed the DDNR with the UM. The surveyor pointed out that the physician/facility staff had not determined whether Resident #5 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

On May 10, 2016 at 4:30 p.m. the surveyor notified the Director of Nursing (DON) that the facility staff failed to ensure a complete and accurate DDNR. The surveyor notified the DON that the facility staff failed to determine whether Resident #5 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative

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F 155	Continued From page 3 Team (AT) that the facility staff failed ensure a complete and accurate DDNR for Resident #5. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate DDNR for Resident #5.	F 155		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 12 residents (Resident #2). The findings include:	F 280	Charge nurse will update 100% of comprehensive care plans daily with all new orders. All new orders will be copied daily and placed in notebook for charge nurse to review and update daily care plan. When appropriate, the plan of care will include participation of the resident, family or legal representative and will be reviewed periodically and revised by the interdisciplinary team. Numerator=number of updated care plans Denominator=number of new orders written	6-17-16

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F 280	Continued From page 4 The facility staff failed to review and revise the comprehensive care plan (CCP) for Resident #2 by failing to delete the care plan for a medication already discontinued. Resident #2 was admitted to the facility on 7/9/15 with diagnoses of stroke, atrial fibrillation, anemia, congestive heart failure, coronary artery disease, dementia, hypertension, depression, osteoporosis, and hypothyroidism. The current significant change Data Set (MDS) with a reference date of 4/12/16 assessed the resident with short and long term memory deficit. The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, bathing, dressing, toileting, eating, and hygiene The clinical record was reviewed. The record contained a telephone order dated 4/15/16 to, " Discontinue Eliquis completely dx: (decreased) hgb ". The CCP was reviewed. A problem was listed the resident was " at risk for bleeding r/t to anticoagulant therapy Eliquis " with a start date of 4/21/16. The charge nurse (RN#1) was asked about the care plan on 5/10/16 at 3:10 p.m. RN#1 stated the CCP should be revised. The administrative team was informed of the finding during a meeting with the survey team on 5/11/16 at 3:30 p.m.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	All nursing will be educated on the components of the physicians order policy. All ordered medications will be documented on the	6/24/16

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to follow physician orders for 1 of 12 Residents in the sample survey, Resident #5.
The Findings Included:
For Resident #5 the facility staff failed to follow physician orders for Resident #5. The facility staff failed to administer physician ordered medications, Fosamax, Lisinopril and Diltiazem. Resident #5 was an 82 year old female who was originally admitted on 8/19/14 and readmitted on 5/13/15. Admitting diagnoses included, but were not limited to: septicemia, depression, hypotension, bacterial pneumonia, acute and chronic respiratory failure, osteoporosis, diabetes mellitus, hypertension, congestive heart failure and emphysema.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #5 required limited (2/2) to extensive assistance (3/3) with Activities of Daily Living (ADL's).
On May 10, 2016 at 3:30 p.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "ALENDRONATE TAB (tablet) 70MG TAKE 1 TABLET EVERY WEEK BY MOUTH BEFORE FIRST FOOD OR WATER. REMAIN UPRIGHT FOR 30 MINUTES. (DUE ON 07/01/2015) (REORDER 3 DAYS BEFORE

medication administration record.
If not given per order, appropriate documentation will be recorded in the medical record as to the name and dose of medication, reason not given and provider notification per policy.
Charge nurse will audit 3 charts per week for compliance per policy. Physician will be notified of noncompliance noted during audits. Corrective action will be issued for nurses not following policy.
Numerator=number of medications not given per policy
Denominator=number of medications ordered

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NEEDED) For Fosamax 8526572RX# Start: 05/25/15. DILTIAZEM HL ER 120MG 1 CAPSULE PO (by mouth) FOR: DILACOR XR 8710192RX# Start 03/03/16. LISINOPRIL TAB 10MG 1 tablet PO Daily For: Zestril 8710191RX# Start 03/03/16." (sic)

Continued review of the clinical record produced the March and April 2016 Medication Administration Records (MAR's). Review of April 2016 MAR's failed to document the administration of the Alendronate (Fosamax) on April 18th and April 25th. The March and April MAR's also documented that the facility staff "held" the physician ordered Lisinopril on March 10th, March 11th, March 14th, Apr 28th and 30th. The Aril 2016 MAR's also documented that the facility staff "held" the Lisinopril and Diltiazem on 4/6/16. Further review of the clinical record failed to produce documentation for specific medication/blood pressure parameters for the administration of the Lisinopril and/or Diltiazem. Additionally, documentation could not be located in the clinical record for the facility staff to "hold" the physician ordered medications.

On May 10, 2016 at 3:55 p.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that the facility staff did not follow physician orders for Resident #5. The surveyor reviewed Resident #5's clinical record with the UM. The surveyor pointed out that the facility staff did not administer the Fosamax on April 18th and 25th. The surveyor also pointed out that the facility staff "held" the Lisinopril and/or Diltiazem in March and April 2016. The surveyor notified the UM that the facility staff did not have physician orders to hold the medications.

On May 10, 2016 at 4:30 p.m. the surveyor notified the Director of Nursing (DON) that the facility staff failed to administer physician ordered

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F 309	Continued From page 7 medications to Resident #5. The surveyor notified the DON that the facility staff did not administer the Fosamax on April 18th and 25th. The surveyor also notified the DON out that the facility staff "held" the Lisinopril and/or Diltiazem in March and April 2015. The surveyor notified the DON that the facility staff did not have physician orders to hold the medications. On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative Team (AT) that the facility staff failed to administer physician ordered medications to Resident #5. No additional information was provided prior to exiting the facility as to why the facility staff failed to administer physician ordered medications to Resident #5.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide nail care to a dependent resident for 1 of 12 Residents in the sample survey, Resident #1.	F 312	Residents will be assessed daily for nail care needs by CNA and documented in the residents medical record. Primary care nurse will cosign daily hygiene assessment. Charge nurse will audit 3 charts weekly for compliance and do visual checks on residents daily. Numerator=number of residents assessed for quality person hygiene by CNA Denominator=number of residents	6/17/16

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The Findings Included:
Resident #1 was a 90 year old female who was originally admitted on 9/2/12 and readmitted on 2/27/13. Admitting diagnoses included, but were not limited to: protein calorie malnutrition, anemia, hemiplegia, anxiety, hypertension, adult failure to thrive, osteoporosis, dementia, chronic kidney disease and osteoarthritis.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 1. The facility staff also coded that Resident #1 required total nursing care with Activities of Daily Living (ADL's).
On May 10, 2016 at 3:25 p.m. the surveyor observed Resident #1 lying in bed. Resident #1 was sleeping and her right hand was lying on top of the bed covers. The surveyor observed that Resident #1's right hand finger nails had brown debris under the free edge of the fingernails.
On May 11, 2016 at 7:45 a.m. the surveyor observed Resident #1 lying in bed. Resident #1 was awake. The surveyor observed Resident #1's right hand. The surveyor noted that Resident #1 had brown debris under the free edge of the fingernails.
On May 11, 2016 at 8:15 a.m. the surveyor requested for the Unit Manager (UM), who was a Registered Nurse (RN), to accompany her to Resident #1's room. The surveyor notified the UM that Resident #1 had a brown debris under the free edge of the fingernails on the right hand. The UM and surveyor walked to Resident #1's room and entered the room. The surveyor pointed out to the UM that Resident #1's fingernail were dirty. The UM stated, "I'll take care of that." The UM walked to the nurses station and asked which staff member was

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F 312	Continued From page 9 assigned to provide care to Resident #1. The UM then informed the staff member that Resident #1 needed nail care. On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative Team (AT) that the facility staff failed to provide nail care to Resident #1. The surveyor notified the AT that Resident #1 had brown debris under her fingernails. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide nail care to Resident #1.	F 312		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	1. All medication administration orders will be followed as written per policy. Charge nurse will review medication orders and observe med pass for compliance twice weekly. Nursing staff will receive education on medication administration policy. Numerator=number of correct med passes Denominator=number of med passes observed	6/24/16

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contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure 4 of 12 residents (Residents #2, #3, #1, and #6) were monitored for medication administration. The findings include:
1. The facility staff failed to follow the physician order to monitor the apical pulse for Resident #2 during a medication pass and pour observation on 5/11/16 at 8:10 a.m.
Resident #2 was admitted to the facility on 7/9/15 with diagnoses of stroke, atrial fibrillation, anemia, congestive heart failure, coronary artery disease, dementia, hypertension, depression, osteoporosis, and hypothyroidism.
The current significant change Data Set (MDS) with a reference date of 4/12/16 assessed the resident with short and long term memory deficit. The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, bathing, dressing, toileting, eating, and hygiene.
The clinical record was reviewed. The physician recertification orders for May 2016 contained an order to administer, " Digox tab 0.125mg 1 tablet daily Check apical pulse for: Lanoxin " .
The nurse administering medication (LPN#1) was observed on 5/11/16 at 8:10 a.m. to check the radial pulse of Resident #2 prior to administering the Digox. LPN was asked about the order following completion of the medication pass observation. LPN#2 stated she should have

F 329

2. All residents on psychotropic medications will have a behavior monitoring log in the medical record to note behaviors during administration of psychotropic medications. Charge nurse will audit al charts daily of patients being administered psychotropic medications for compliance of behavior documentation. Corrective action will be give to nursing not following correct process. 6/24/16

numerator=number of residents with completed behavior log
denominator=number of residents receiving psychotropic medications

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checked the apical pulse.
The administrative team was informed of the finding during a meeting with the survey team on 5/11/16 at 3:30 p.m.

2. The facility staff failed to monitor behaviors for Resident #3 receiving antipsychotic medications.

Resident #3 was admitted to the facility on 1/12/15 with diagnoses of Alzheimer ' s disease, dementia with behaviors, Parkinson ' s disease, depression, anxiety, coronary artery disease, hypertension, anemia, malnutrition, urinary tract infection, dysphagia, and osteoporosis.

The current quarterly Minimum Data Set (MDS) with a reference date of 2/25/16 assessed the resident with a cognitive score of " 9 " of " 15 ". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, and bathing.

The clinical record was reviewed. The physician ordered the antipsychotic medication, Seroquel 25 mg every bedtime, antidepressant, Sertraline 50 mg daily, and antianxiety medication, Xanax 0.5 mg three times daily as needed.

The comprehensive care plan contained a problem listed the resident received daily doses of psychotropic medication and is at risk of side effects. The interventions noted the resident was to be monitored for mood daily and to monitor for effectiveness and side effects of the medications and report any changes to the physician. The resident was noted to be confused at times and agitated with inappropriate behaviors.

The clinical record was reviewed and no evidence of medication monitoring was found in the record.

The charge nurse (RN#1) was asked on 5/10/16 at 3:00 p.m. about behavior monitoring. RN#1 stated they did not do this.

The administrative team was informed of the

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finding during a meeting with the survey team on 5/11/16 at 3:30 p.m.

3. For Resident #1 the facility staff failed to ensure that Resident #1 was free from unnecessary medications. The facility staff failed to monitor for the administration of a psychotropic medication, Seroquel, to include specific behaviors, side effects, effectiveness and interventions.

Resident #1 was a 90 year old female who was originally admitted on 9/2/12 and readmitted on 2/27/13. Admitting diagnoses included, but were not limited to: protein calorie malnutrition, anemia, hemiplegia, anxiety, hypertension, adult failure to thrive, osteoporosis, dementia, chronic kidney disease and osteoarthritis.

The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 1. The facility staff also coded that Resident #1 required total nursing care with Activities of Daily Living (ADL's).

On May 11, 2016 at 7:55 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to the follow: "QUETIAPINE TAB (tablet) 50MG 1 tablet via tube twice daily For: Seroquel 8710038RX# Start: 01/05/15." (sic)

Continued review of the clinical record failed to produce behavior monitoring documentation for the monitoring of the Seroquel drug use, to include specific behaviors, side effects, effectiveness and interventions.

On May 11, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that behavior monitoring documentation for the use of a psychotropic

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medication use, Seroquel, could not be located in the clinical record. The surveyor reviewed Resident #1's clinical record with the UM. The surveyor pointed out the specific physician order for the Seroquel. The UM stated that she did not know what the surveyor was asking for. The surveyor explained that when a resident is receiving a psychotropic medication the facility staff must document specific behaviors, effectiveness, side effects and other interventions attempted by the facility staff. The UM stated, "Oh, we don't do that."
On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #1 for psychotropic drug use. The surveyor notified the AT that Resident #1 was receiving Seroquel and that review of the clinical record failed to produce psychotropic drug monitoring.
No additional information was provided prior to exiting the facility as to why the facility staff failed to monitor Resident #1 for psychotropic drug use, Seroquel.
4. For Resident #6, the facility staff failed to provide monitoring for the antipsychotic medications Geodon and Seroquel.

Resident #6 was admitted to the facility on 09/24/15. Diagnoses included but not limited to anxiety, depression, anemia, hypertension, peripheral vascular disease, hyperlipidemia, dementia, Parkinson's disease, malnutrition, coronary artery disease, end stage renal disease, and thyroid disorder.

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F 329	Continued From page 14 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/04/16 coded the Resident as 01 out of 15 in Section C, cognitive status. This is a quarterly MDS. Resident #6's clinical record was reviewed on 05/11/16. It contained a signed physician's order summary dated 04/30/16 which read in part "Quetiapine tab 50mg 1 tablet PO (by mouth) at bedtime For: Seroquel" and "Ziprasidone Cap 60mg 1 capsule PO with breakfast and with supper For: Geodon". The Resident's clinical record contained no evidence of behavior monitoring for the medications. Surveyor asked the unit manager about the lack of monitoring and unit manager stated that they had never done that. The concern over the lack of monitoring was brought to the attention of the administrative staff during a meeting on 05/11/16 at approximately 1530. No further information was provided prior to exit.	F 329		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425	Pharmacy will be notified upon receipt of new medication orders by fax. When a medication is not recieved within 16 hrs, the charge nurse will be notified by the primary care nurse. The charge nurse will contact the pharmacy to inquire about the medication.	6/24/16

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acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure that physician ordered medications were available for administration for 3 of 12 Residents in the sample survey, Resident #1, Resident #2 and Resident #8.
The Findings Included:
1. For Resident #1 the facility staff failed to ensure that physician ordered Zinc Oxide and Remeron were available for administration.
Resident #1 was a 90 year old female who was originally admitted on 9/2/12 and readmitted on 2/27/13. Admitting diagnoses included, but were not limited to: protein calorie malnutrition, anemia, hemiplegia, anxiety, hypertension, adult failure to thrive, osteoporosis, dementia, chronic kidney disease and osteoarthritis.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 1. The facility staff also coded that Resident #1 required total nursing care with Activities of Daily Living (ADL's).

If medication is still not available, physician will be notified for alternative or change in order. All medications deemed unavailable by pharmacy will be monitored to ensure medication, alternative, or change in orders is received within 24 hrs per policy. Charge nurse will monitor pharmacy compliance weekly.

Numerator=number of initial medications not received or alternative not received per policy
Denominator=Number of new medications ordered

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F 425	Continued From page 16 On May 11, 2016 at 7:55 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to the follow: "ZINC OXIDE OIN (ointment) 20% Apply TOPICALLY TO G-TUBE SITE EVERY SHIFT (REORDER 3 DAYS BEFORE NEEDED) 861099RX#." (sic) Additionally a physician order written on 3/25/16 ordered for Resident #1 to receive Remeron 15 mg by mouth every evening before bedtime. Continued review of the clinical record produced the March 2016 Medication Administration Records (MAR's). Review of the March 2016 MAR's documented that the physician ordered Zinc Oxide was not available for administration on 3/28/16. The March 2016 MAR's also documented that the Remeron was not available for administration on 3/25/16. On May 11, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN) that the facility staff documented that Resident #1's physician ordered Zinc Oxide and Remeron were not available in March 2016. The surveyor reviewed Resident #1's clinical record with the UM. The surveyor pointed out the specific order for the Zinc Oxide and Remeron. The surveyor then reviewed the March 2016 MAR's with the UM. The surveyor pointed out that the facility staff documented on March 25, 2016 that Resident #1's physician ordered Remeron was not available for administration. The surveyor also pointed out that the facility staff documented on 3/28/16 that the physician ordered Zinc Oxide was not available for administration. The surveyor asked if the facility had a backup pharmacy and the UM stated, "Yes." On May 11, 2016 at 2:30 p.m. the surveyor	F 425		

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reviewed the facility policy and procedure titled, "Unavailable Medications." The policy and procedure read in part ...
"Policy: On occasion, a medication ordered for a resident in the nursing facility may be unavailable for dispensing from the 24 hour pharmacy. This may result from the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of a drug, or the situation may be permanent because the drug is no longer be manufactured.
The nursing staff must make every effort to ensure that a medication ordered for the resident is available to meet their needs.
Procedure: the nursing staff shall, if the shortage will impact the patient's immediate need of the ordered product:
A. Check the STAT medication box for availability of medication.
B. Contact after hours pharmacy for availability of medication . ...." (sic)
On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure that physician ordered medications, Zinc Oxide and Remeron, were available for administration for Resident #1.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medications were available for administration for Resident #1.
2. The facility staff failed to ensure Resident #2 had the antidepressant, Effexor, available for administration. The facility staff failed to ensure the medication, Synthroid 88mcg (for

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hypothyroidism) was available for administration.

a) The facility staff failed to ensure Resident #2 had the antidepressant, Effexor, available for administration.

Resident #2 was admitted to the facility on 7/9/15 with diagnoses of stroke, atrial fibrillation, anemia, congestive heart failure, coronary artery disease, dementia, hypertension, depression, osteoporosis, and hypothyroidism.
The current significant change Data Set (MDS) with a reference date of 4/12/16 assessed the resident with short and long term memory deficit. The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, bathing, dressing, toileting, eating, and hygiene.

The clinical record was reviewed. The physician ordered Effexor 75mg to be administered every night for 1 week beginning on 3/5/16 and to increase to 150mg every night after the 75mg were completed.

The medication administration record (MAR) fro March 2016 was reviewed. The nurse circled her initials indicating the medication was not given. The nurse documented on the back of the MAR for 3/10/16,3/11/16, and 3/12/16 that the "Effexor was not in the drawer and the pharmacy was faxed" on 3/10. The nurse documented the Effexor 75mg was "still not from the pharmacy" on 3/11/16. The nurse also documented the" Effexor 150mg was not available faxed to pharmacy again" on 3/12/16.

b). The facility staff failed to ensure the medication, Synthroid 88mcg (for hypothyroidism) was available for administration.

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The clinical record was reviewed and revealed a physician order for Levothyroxin tab 88mcg 1 tablet po (by mouth) before breakfast for: Synthroid beginning 4/6/16.

The medication administration record (MAR) for May 2016 was reviewed. The nurse had circled her initials indicating the Synthroid had not been administered on 5/5, 5/6, 5/7, 5/8, and 5/9. The nurse documented on the back of the MAR the meds were not available on those dates for administration.

The charge nurse stated on 5/11/16 at approximately 10:00 a.m. the facility had a back up local pharmacy for long term care residents and the pharmacy could be called after hours.

The administrative team was informed of the finding during a meeting with the survey team on 5/11/16 at 3:30 p.m.
3. The facility staff failed to ensure medication was available for administration for Resident#8.

Resident #8 was admitted to the facility on 2/8/16 with diagnoses of sinusitis, malnutrition, anxiety, depression, anemia, deep vein thrombosis, hypertension, arthritis, dementia, and osteoporosis.

The significant change Minimum Data Set (MDS) with a reference date of 4/11/16 assessed the resident with a cognitive score of "14" of "15". The resident was assessed requiring extensive assistance of 1 person for transfers, ambulation in room, dressing, toileting, hygiene, and bathing.

The clinical record was reviewed. The record

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F 425	Continued From page 20 contained a physician written order dated 4/8/16 for, "Singulair 10mg q hs (every bedtime) as directed for seasonal allergies, sinusitis". The April 2016 medication administration record (MAR) was reviewed. The nurse circled her initials on the front of the MAR and documented on the back of the MAR for 4/8/ and 4/9 , "not given Singulair med not available". The administrative team was informed of the finding during a meeting with the survey team on 5/11/16 at 3:30 p.m.	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered laboratory test for 1 of 12 Residents, Resident #6. Resident #6 was admitted to the facility on 09/24/15. Diagnoses included but not limited to anxiety, depression, anemia, hypertension, peripheral vascular disease, hyperlipidemia, dementia, Parkinson's disease, malnutrition, coronary artery disease, end stage renal disease, and thyroid disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/04/16	F 502	Charge nurse will review all diagnostic orders daily for completion. Charge nurse will verify daily that results have been received and placed in medical record. The physician will be notified of any abnormal results and documented in the medical record per policy. Numerator=number of diagnostic orders written Denominator=Number of diagnostic results received	6/10/16

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F 502	Continued From page 21 coded the Resident as 01 out of 15 in Section C, cognitive status. This is a quarterly MDS. Resident #6's clinical record was reviewed on 05/11/16. It contained a signed physician's order dated 02/22/16 which read in part "CXR (chest x-ray) CMP (comprehensive metabolic panel) CBC (complete blood count) U/A C&S (urinalysis with culture and sensitivity)". The surveyor could not locate the results for the U/A with C&S. The surveyor asked the unit manager if she could locate the missing lab results and she could not. The concern of the missing lab report was brought to the attention of the administrative staff during a meeting on 05/11/16 at approximately 1530. No further information was provided prior to exit.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	All of residents physician order sheets will be reviewed monthly by designated nurse and checked for accuracy of medication, routes given, treatments and restraint orders. If a medication that is ordered cannot be administered via route designated by the MD order, the primary care nurse will contact MD for clarification/ verification and other options for administration.	6/29-16

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by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 2 of 12 Residents in the sample survey. Resident #1 and Resident #6.
The Findings Included:
1. For Resident #1 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's) and Medication Administration Records (MAR's).
Resident #1 was a 90 year old female who was originally admitted on 9/2/12 and readmitted on 2/27/13. Admitting diagnoses included, but were not limited to: protein calorie malnutrition, anemia, hemiplegia, anxiety, hypertension, adult failure to thrive, osteoporosis, dementia, chronic kidney disease and osteoarthritis.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 3/31/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 1. The facility staff also coded that Resident #1 required total nursing care with Activities of Daily Living (ADL's).
On May 11, 2016 at 7:55 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced signed physician orders. Signed POS's included, but were not limited to: "NPO (nothing by mouth) Ice Chips Only. Oxycodone Tab 10MG ER '2 Tabs' (20mg) by mouth EVERY 12 Hours **Note Dosage Strength**8719225RX# Start: 04/19/16. Lorazepam Tab 0.5mg 1 tablet po (by mouth) Q (every) 6 hours PRN (as needed) For: Ativan 7279744RX# Start: 04/08/15. MAPAP Tab 500mg 1 tablet PO Daily as needed for pain/elevated Temp (temperature) **Max acetaminophen dose=300mg in 24 hours from all

Numerator=number of residents with updated physician order sheets
Denominator=number of residents with new orders

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sources** 5226605RX# Start: 11/22/13. Ondansetron Tab 4 mg 1 tablet po Q4-6 hours PRN For: Zofran 7559794RX Start: 06/03/15 DX (diagnoses): Nausea and Vomiting." (sic)
Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP revealed a care plan that identified that Resident #1 was on Comfort Care.
On May 11, 2016 at 8:15 a.m. the surveyor asked the Unit Manager (UM), who was a Registered Nurse (RN), how Resident #1 received her medications. The UM stated that Resident #1 received her medications by PEG tube (percutaneous endoscopic gastrostomy). The surveyor notified the UM that the facility staff failed to ensure complete and accurate POS's. The surveyor notified the UM that most of Resident #1's medications were ordered via PEG tube: however, some of her medications were ordered to be administered by mouth. The surveyor reviewed the clinical record with the UM. The surveyor reviewed the physician signed POS's and the May and April 2016 MAR's with the UM. The surveyor pointed out that some of Resident #1's medications were ordered to be given by mouth: however, Resident #1 was ordered to be NPO and had a PEG tube. The surveyor also asked if Resident #1 was on Comfort Care and the UM stated, "Yes." The surveyor notified the UM that the CCP included a care plan for Comfort Care, however, the POS's did not contain an order for Comfort Care.
On May 11, 2016 at 2:30 p.m. the UM hand delivered a physician telephone order dated 6/26/13 that read in part ... "I discussed care yesterday with (name withheld). Pt (patient) is palliative care. ..." (sic) The UM stated that she had located the order for palliative care in medical records from the thinned record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. BUILDING _____ B. WING _____	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	310 THIRD STREET, NE NORTON, VA 24273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 24 On May 11, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Chief Nursing Officer (CNO), Quality Assurance Nurse (QAN), Chief Financial Officer (CFO), Maintenance Director (MD) and UM. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate POS's and MAR's for Resident #1. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate POS's and MAR's for Resident #1. 2. For Resident #6 the facility staff failed to ensure the physician's order for "lap buddy" was included on the POS (physician's order summary). Resident #6 was admitted to the facility on 09/24/15. Diagnoses included but not limited to anxiety, depression, anemia, hypertension, peripheral vascular disease, hyperlipidemia, dementia, Parkinson's disease, malnutrition, coronary artery disease, end stage renal disease, and thyroid disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/04/16 coded the Resident as 01 out of 15 in Section C, cognitive status. This is a quarterly MDS. Resident #6's clinical record was reviewed on 05/11/16. It contained a signed physician's order dated 11/05/15 which read in part "Lap buddy". The most recent POS dated 04/3016 was reviewed and the surveyor could not locate the order for a lap buddy on the POS. Surveyor asked the unit manager about the missing order and she stated that she did not know why it was	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. BUILDING _____ B. WING _____	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	310 THIRD STREET, NE NORTON, VA 24273

(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
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not on the POS.

The concern of missing order was brought to the attention of the administrative staff during a meeting on 05/11/16 at approximately 1530.

No further information was provided prior to exit.