

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, BS, RN Director of Risk/Quality

Lonesome Pine/Mountain View Regional Medical Center

PRINTED: 05/26/2016 FORM APPROVED OMB NO. 0938-0391

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The facility must comply with the requirements lecified in subpart I of part 489 of this chapter ated to maintaining written policies and ocedures regarding advance directives. These quirements include provisions to inform and bride written information to all adult residents incerning the right to accept or refuse medical surgical treatment and, at the individual's stion, formulate an advance directive. This cludes a written description of the facility's licies to implement advance directives and	WIEW REGIONAL MEDICAL CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ITTIAL COMMENTS  In unannounced Medicare/Medicaid standard strey was conducted 5/10/16 through 5/11/16. Directions are required for compliance with 42 FR Part 483 Federal Long Term Care quirements. The Life Safety Code strey/report will follow.  The census in this 44 certified bed facility was 36 the time of the survey. 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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 housing 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.

Facility ID: VA0237

PRINTED: 05/26/2016 FORM APPROVED OMB NO. 0938-0391

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	by: Based on staff intereview, it was detentable to ensure a composition of the sample surve. The Findings Include For Resident #5 the complete and accur. Resuscitate (DDNR Resident #5 was an originally admitted of 5/13/15. Admitting on the limited to septic hypotension, bacter chronic respiratory for mellitus, hypertension and emphysema. The most current M located in the clinical assessment with an (ARD) of 3/31/16. The facility staff required limited (2/2 (3/3) with Activities of the clinical record procession and the DDNR was not a DDNR had not docuwas Capable or Incadecision about provided.	ed: I facility staff failed to ensure a ate Durable Do Not  ).  82 year old female who was on 8/19/14 and readmitted on diagnoses included, but were remanded, but were remanded, all pneumonia, acute and failure, osteoporosis, diabetes on, congestive heart failure  Inimum Data Set (MDS) all record was a Quarterly MDS Assessment Reference Date of facility staff coded that cognitive Summary Score of also coded that Resident #5 of Daily Living (ADL's).  3:30 p.m. the surveyor resistance of coduced a Durable Do Not of Daily Living (ADL's).  The DDNR was dated the DDNR sheet revealed that accurate/complete. The mented whether Resident #5 apable of making an informed ding, withholding or medical treatment or course				

Facility ID. VA0237

F 155 Continued From page 2 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 physiciary 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. 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 rotified 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.	CENTERS FOR MEDICAN	E & MEDICAID OFILAIOFO			1	
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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	Reference: Code Durable Do Not Resuscital physician for his p fide physician/pati the guidelines of the with the consent of a minor or is other informed decision order, upon the rethe person authorities the Unit M Registered Nurse was incorrect/inact the clinical record reviewed the DDN pointed out that the determined whether Incapable of making providing, withhold medical treatment.  On May 10, 2016 anotified the Director facility staff failed the accurate DDNR. that the facility staff resident #5 was an informed decisior withdrawing specourse of medical On May 11, 2016 and met with the Admir Nurses (DON), Chilling Quality Assurance Officer (CFO), Mai	of Virginia § 512.1-2987.1. esuscitate Orders. A. A Durable e Order may be issued by a atient with whom he has a bona ent relationship as defined in the Board of Medicine, and only if the patient or, if the patient is wise incapable of making an regarding consent for such an quest of and with the consent of zed to consent on the patient's at 3:55 p.m. the surveyor enager (UM), who was a (RN), that Resident #5's DDNR curate. The surveyor reviewed with the UM. The surveyor en physician/facility staff had not are Resident #5 was Capable or an informed decision abouting or withdrawing specific or course of medical at 4:30 p.m. the surveyor rof Nursing (DON) that the consure a complete and the surveyor notified the DON of failed to determine whether apable or incapable of making on about providing, withholding cific medical treatment or restment.  It 3:30 p.m. the survey team istrator (Adm), Director of the Nursing Officer (CNO), Nurse (QAN), Chief Financial intenance Director (MD) and	F 18			

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					NO. 0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		STRUCTION		DATE SURVEY COMPLETED
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MOUNTA	IN VIEW REGIONAL			NORT	ON, VA 24273	TI/ON	(¥5)
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	Team (AT) that the	facility staff failed ensure a					
	complete and accu	rate DDNR for Resident #5.					
	No additional inform	nation was provided prior to					
	exiting the facility a	s to why the facility staff failed te and accurate DDNR for					
	Resident #5.	te and accorate DDITTO					
E 000		N/V2\ RIGHT TO	F 2	280			
F 280	PARTICIPATE PLA	NNING CARE-REVISE CP		harge	nurse will update 100%		6-17-16
SS=D	PARTIONALLICA	THE STATE OF THE S				ilv	,
	The resident has th	e right, unless adjudged			rehensive care plans da		
	incompetent or other	erwise found to be	V	vith all r	new orders. All new ord	ers	
	incapacitated unde	r the laws of the State, to	1.6	vill he c	copied daily and placed		
	participate in plann	ing care and treatment or					
	changes in care an	d treatment.			ook for charge nurse to		
		the development	r	eview a	and update daily care pla	an.	
	A comprehensive of	are plan must be developed	V	Nhen a	ppropriate, the plan of c	are	
	within 7 days after	the completion of the					
	comprehensive ass	sessment; prepared by an im, that includes the attending	V	VIII INCII	ude participation of the		
	interdisciplinary tea	red nurse with responsibility	r	esiden	t, family or legal represe	ntativ	e
	physician, a registe	d other appropriate staff in	5	and will	be reviewed periodically	/ and	
1	for the resident, an	mined by the resident's needs,					
1	and to the extent of	racticable, the participation of	F	evisea	by the interdisciplinary t	Carri,	-1
	the resident the re	sident's family or the resident's	1	Numera	ator=number of updated	care	pians
	Jegal representative	e: and periodically reviewed	ī	Denom	inator=number of new o	ders	written
	and revised by a te	am of qualified persons after					
]	each assessment.						
	This REQUIREME	NT is not met as evidenced					
	by:	191 10 1100 1100					
	Based on staff into	erview and clinical record					
1	review the facility:	staff failed to review and revise					
	the comprehensive	care plan for 1 of 12 residents					
	(Resident #2).						
	The findings includ	e:					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		495374	B WNG		05/11/2016
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TOPNING
F 309	comprehensive can by failing to delete to already discontinue Resident #2 was act with diagnoses of sicongestive heart fail dementia, hypertent osteoporosis, and had the current signification with a reference dairesident with short at The resident was assistance of 1 persolation bathing, dressing, to the contained a telephoropiscontinue Eliquis hab ".  The CCP was revier resident was " at rist anticoagulant theraly 4/21/16.  The charge nurse (I care plan on 5/10/16 the CCP should be The administrative to finding during a meet 5/11/16 at 3:30 p.m. 483.25 PROVIDE CONTRIBUTED THE BETT WELL BETT THE CARE TO THE CONTRIBUTED THE CONTRIB	ed to review and revise the e plan (CCP) for Resident #2 he care plan for a medication d. Imitted to the facility on 7/9/15 troke, atrial fibrillation, anemia, dure, coronary artery disease, sion, depression, typothyroidism. In the angle Data Set (MDS) the of 4/12/16 assessed the and long term memory deficit, assessed requiring extensive son for bed mobility, transfers, colleting, eating, and hygiene was reviewed. The record me order dated 4/15/16 to, "completely dx: (decreased) wed. A problem was listed the sk for bleeding r/t to by Eliquis" with a start date of RN#1) was asked about the 6 at 3:10 p.m. RN#1 stated revised.  LARE/SERVICES FOR EING	F 2		6/24/16
	provide the necessar or maintain the high mental, and psycho-	ery care and services to attain est practicable physical,		physicians order policy.  All ordered medications will be documented on the	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				B NO. 0938-0391
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F 309	Continued From pa	ge 5	F	309		
	by: Based on staff intereview, it was deterfailed to follow physics Residents in the sather Findings Included For Resident #5 the physician orders for staff failed to adminimedications, Fosan Resident #5 was an originally admitted to 5/13/15. Admitting not limited to: septic hypotension, bacter chronic respiratory mellitus, hypertensiand emphysema. The most current Milocated in the clinical assessment with an (ARD) of 3/31/16. Resident #5 had a to 12. The facility staff required limited (2/2 (3/3) with Activities On May 10, 2016 and the clinical record produced or signed phywere not limited to: 70MG TAKE 1 TAB MOUTH BEFORE IN REMAIN UPRIGHT	e facility staff failed to follow Resident #5. The facility ister physician ordered hax, Lisinopril and Diltiazem. 82 year old female who was on 8/19/14 and readmitted on diagnoses included, but were	If indo in an give Circle with the best of the circle of t	edication administration renot given per order, appropried and provider as to the dose of medication, reaven and provider notification arge nurse will audit 3 charge nurse per policy. Fill be notified of noncomplicated during audits. Correct issued for nurses not follower per policy enominator=number of medical per policy en	priate ded he name ison not on per po narts per v Physician ance ctive actio lowing po- ications n	veek n will licy. ot

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 310 THIRD STREET, NE NORTON, VA 24273		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DA <sup>T</sup> E
	NEEDED) For Fosa 05/25/15. DILTIAZE CAPSULE PO (by r 8710192RX# Start of 10MG 1 tablet PO IS Start 03/03/16." (sic Continued review of the March and April Administration Recc 2016 MAR's failed to of the Alendronate (April 25th. The Mardocumented that the physician ordered L 11th, March 14th, Al 2016 MAR's also do staff "held" the Lisin Further review of the produce documental medication/blood produced documental medication/blood produced to the physician ordered Cn May 10, 2016 at notified the Unit Mar Registered Nurse (Finot follow physician surveyor reviewed Finot follow physician orders to the UM that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th. Out that the facility staff did not a April 18th and 25th.	imax 8526572RX# Start: IM HL ER 120MG 1 mouth) FOR: DILACOR XR D3/03/16. LISINOPRIL TAB Daily For: Zestril 8710191RX# ) If the clinical record produced 2016 Medication ords (MAR's). Review of April to document the administration Fosamax) on April 18th and the and April MAR's also the facility staff "held" the disinopril on March 10th, March to 28th and 30th. The Aril tournented that the facility topril and Diltiazem on 4/6/16. The clinical record falled to tion for specific the saure parameters for the the Lisinopril and/or Diltiazem. The product of the facility staff to "hold"	F	309		

OLIVIL.	TO LOIL MEDIOMILE	OF MICHIGAND OF LAMORO			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495374	B. WiNG	1	05/11/2016
	PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 THIRD STREET, NE NORTON, VA 24273	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
F 312 SS=D	notified the DON the administer the Fosa The surveyor also of facility staff "held" the in March and April 2 the DON that the facility staff "held" the DON that the facility as the DON, Chie Quality Assurance Norses (DON), Chie Quality Assurance Norses (AT) that the fadminister physiciar Resident #5.  No additional inform exiting the facility as to administer physic Resident #5.  483.25(a)(3) ADL CODEPENDENT RESIDENT R	dent #5. The surveyor at the facility staff did not amax on April 18th and 25th. notified the DON out that the facility staff did not have hold the medications.  3:30 p.m. the survey team strator (Adm), Director of st Nursing Officer (CNO), surse (QAN), Chief Financial tenance Director (MD) and otified the Administrative facility staff failed to a ordered medications to atton was provided prior to attom was provided prior to why the facility staff failed in ordered medications to a determined that the facility and care to a dependent Residents in the sample	F3R da a m c C c d	Residents will be assessed aily for nail care needs by CNA and documented in the residents nedical record. Primary care nur osign daily hygiene assessment. Charge nurse will audit 3 charts wompliance and do visual checks laily.  Sumerator=number of residents are quality person hygiene by CNA denominator=number of residents.	veekly for on residents

CENTE	45 FUR MEDICARE	& MEDICAID OF MAIOE				THE PART OF THE PARTY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495374	B. WING			05/11/2016
	PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY 310 THIRD STREET, M NORTON, VA 24273	NE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION SHOULD NOED TO THE APPROPROFICIENCY)	BE COMPLETION
F 312	originally admitted of 2/27/13. Admitting not limited to: prote hemiplegia, anxiety thrive, osteoporosis disease and osteoa. The most current M located in the clinic with an Assessmen 3/31/16. The facilit had a Cognitive Su staff also coded than ursing care with A On May 10, 2016 a observed Resident was sleeping and hof the bed covers. Resident #1's right debris under the free On May 11, 2016 at observed Resident was awake. The su #1's right hand. The Resident #1 had bredge of the fingerna On May 11, 2016 at requested for the URegistered Nurse (Resident #1's room UM that Resident # the free edge of the The UM and survey room and entered the pointed out to the Usingernail were dirty care of that." The Usingernail were dirty care of that."	led; 90 year old female who was on 9/2/12 and readmitted on diagnoses included, but were in calorie malnutrition, anemia, hypertension, adult failure to is, dementia, chronic kidney withritis.  Ilinimum Data Set (MDS) all record was a Quarterly MDS to Reference Date (ARD) of y staff coded that Resident #1 mmary Score of 1. The facility at Resident #1 required total ctivities of Daily Living (ADL's). to 3:25 p.m. the surveyor #1 lying in bed. Resident #1 er right hand was lying on top The surveyor observed that hand finger nails had brown be edge of the fingernails. to 7:45 a.m. the surveyor #1 lying in bed. Resident #1 arveyor observed Resident #1 arveyor observed Resident es urveyor noted that own debris under the free	F	312		

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			IMB NO. 0936-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495374	.B. WING		05/11/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	IN VIEW REGIONAL	MEDICAL CENTER		310 THIRD STREET, NE NORTON, VA 24273	
(X4) ID PREFIX TAG	JEACH DESIGNATION	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
E 312	Continued From pa	ae 9	F:	312	
F 329	assigned to provide then informed the s needed nail care. On May 11, 2016 at met with the Admini Nurses (DON), Chir Quality Assurance I Officer (CFO), Mair UM. The surveyor Team (AT) that the nail care to Resider the AT that Resider her fingernails. No additional inform exiting the facility a to provide nail care 483.25(I) DRUG REUNNECESSARY D	care to Resident #1. The UM taff member that Resident #1 : 3:30 p.m. the survey team istrator (Adm), Director of ef Nursing Officer (CNO), Nurse (QAN), Chief Financial intenance Director (MD) and notified the Administrative facility staff failed to provide int #1. The surveyor notified int #1 had brown debris under mation was provided prior to s to why the facility staff failed to Resident #1.	1./	329 All medication administration orders will be followed as	6/24/16
	unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its usadverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessal as diagnosed and record; and resider drugs receive grad	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any ereasons above.  The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical hts who use antipsychotic ual dose reductions, and stions, unless clinically	4	written per policy. Charge nurse will review medication orders and observe med pass for complweekly. Nursing staff will receive education on medication administ policy.  Numerator=number of correct med personal parts and parts.	tration ed passes

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495374	B. WING_		05/11/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MOUNTA	IN VIEW REGIONAL	MEDICAL CENTER		310 THIRD STREET, NE NORTON, VA 24273				
				PROVIDER'S PLAN OF CORRECTI	ON (X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
F 220	Cantinued From no	an 10	F 32	0				
F 328	Continued From pa	an effort to discontinue these			6/2//16			
	drugs.	21, 01101110 01000111110		All residents on psychotropic	0/24/10			
				edications will have a				
				ehavior monitoring log in the				
				edical record to note behavior				
This REQUIREM		IT is not mot an avidenced		uring administration of psychot				
		NI IS NOT THE AS EVIDENCED		edications. Charge nurse will	notropic 6/24/16  In the ehaviors esychotropic rise will audit alleing ic medications or documentation. give to nursing not esidents with			
	Based on observat	ion, staff interview and clinical		harts daily of patients being				
	record review, the f	acility staff failed to ensure 4 sidents #2, #3, #1, and #6)		administered psychotropic medications				
	were monitored for	medication administration.	for compliance of behavior documentation.  Corrective action will be give to nursing not					
	The findings include	e:						
	1. The facility staf	f failed to follow the physician apical pulse for Resident #2		ollowing correct process.				
	during a medication	pass and pour observation						
	on 5/11/16 at 8:10 a	a.m.						
	Resident #2 was ac	Imitted to the facility on 7/9/15 troke, atrial fibrillation, anemia,	(	numerator=number of resident	s with			
:	congestive heart fai	ilure, coronary aftery disease,		completed behavior log				
	dementia, hyperten	sion, depression,		denominator=number of reside	nts receiving			
	osteoporosis, and h	nypothyroidism. ant change Data Set (MDS)			ind to containing			
	with a reference da	te of 4/12/16 assessed the		psychotropic medications				
	resident with short a	and long term memory deficit.						
	The resident was as	ssessed requiring extensive son for bed mobility, transfers,						
	bathing, dressing, to	pileting, eating, and hygiene.						
	The clinical record	was reviewed. The physician						
	recertification order	s for May 2016 contained an "Digox tab 0.125mg 1 tablet						
	daily Check apical	pulse for: Lanoxin " .						
	The nurse administ	ering medication (LPN#1) was						
	observed on 5/11/10	6 at 8:10 a.m. to check the dent #2 prior to administering						
	the Digox, LPN was	asked about the order						
	following completion	n of the medication pass						
	observation, LPN#2	stated she should have						

CENTERS FOR MEDICARE & MEDICARD GERVIOLG		& MEDICAID BEITMOLD				(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	4	TIPLE C	ONSTRUCTION	COMPLETED
		495374	B. WING			05/11/2016
	ROVIDER OR SUPPLIER	MEDICAL CENTER		310	ET ADDRESS, CITY, STATE, ZIP CODE THIRD STREET, NE RTON, VA 24273	
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	finding during a me 5/11/16 at 3:30 p.m 2. The facility staff for Resident #3 recomedications. Resident #3 was at 1/12/15 with diagnor dementia with behat depression, anxiety hypertension, aneminfection, dysphagia. The current quarter with a reference daresident with a cognitive to the resident was a assistance of 1 per dressing, toileting, and the clinical record.	pulse. team was informed of the eting with the survey team on f failed to monitor behaviors eiving antipsychotic  dmitted to the facility on uses of Alzheimer 's disease, eviors, Parkinson 's disease, eviors, Parkinson 's disease, eviors, malnutrition, urinary tract a, and osteoporosis. dy Minimum Data Set (MDS) te of 2/25/16 assessed the initive score of "9" of "15" usessed requiring extensive son for bed mobility, transfers, and bathing. was reviewed. The physician	F	329		
	ordered the antipsy 25 mg every bedtin 50 mg daily, and ar 0.5 mg three times. The comprehensive problem listed the rof psychotropic me effects. The interveto be monitored for effectiveness and sand report any charesident was noted agitated with inapp. The clinical record of medication monitored the charge nurse (at 3:00 p.m. about stated they did not	chotic medication, Seroquel ne, antidepressant, Sertraline ntianxiety medication, Xanax daily as needed. The care plan contained a resident received daily doses dication and is at risk of side entions noted the resident was mood daily and to monitor for side effects of the medications nges to the physician. The to be confused at times and repriate behaviors. The was reviewed and no evidence toring was found in the record. RN#1) was asked on 5/10/16 behavior monitoring. RN#1				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ONSTRUCTION		TE SURVEY
		495374	B. WING			05	5/11/2016
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTA	AIN VIEW REGIONAL	MEDICAL CENTER			THIRD STREET, NE TON, VA 24273		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	PREFID TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	5/11/16 at 3:30 p.m  3. For Resident #* ensure that Resider unnecessary medic to monitor for the ad medication, Seroqu behaviors, side effe interventions. Resident #1 was a soriginally admitted of 2/27/13. Admitting not limited to: protein hemiplegia, anxiety, thrive, osteoporosis disease and osteoa The most current M located in the clinical with an Assessment 3/31/16. The facility had a Cognitive Sur staff also coded tha nursing care with Ac On May 11, 2016 at reviewed Resident # the clinical record pi orders. Signed phys were not limited to to (tablet) 50MG 1 tabl Seroquel 871003BR Continued review of produce behavior m the monitoring of the include specific beha effectiveness and in On May 11, 2016 at notified the Unit Mar Registered Nurse (Fi	ating with the survey team on the facility staff failed to the #1 was free from ations. The facility staff failed diministration of a psychotropic et, to include specific cts, effectiveness and et an effectiveness and et al. (a) year old female who was en 9/2/12 and readmitted on diagnoses included, but were in calorie malnutrition, anemia, hypertension, adult failure to dementia, chronic kidney rithritis. (a) inimum Data Set (MDS) et record was a Quarterly MDS et Reference Date (ARD) of et staff coded that Resident #1 mmary Score of 1. The facility the Resident #1 required total etivities of Daily Living (ADL's). 7:55 a.m. the surveyor et sclinical record. Review of roduced signed physician sician orders included, but the follow: "QUETIAPINE TAB et via tube twice daily For X# Start: 01/05/15." (sic) the clinical record failed to onitoring documentation for exercise side effects.	F 3	29			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495374	B. WING			05/11/2016	
	PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, S 310 THIRD STREET, NE NORTON, VA 24273			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE FICIENCY)	BE COMPLETION	
F 329	medication use, Se the clinical record. Resident #1's clinic surveyor pointed or for the Seroquel. T know what the surveyor explained receiving a psychot staff must document effectiveness, side attempted by the fa "Oh, we don't do the On May 11, 2016 at met with the Admini Nurses (DON), Chie Quality Assurance Mofficer (CFO), Main UM. The surveyor ream (AT) that the Resident #1 for psy surveyor notified the receiving Seroquel record failed to procomonitoring. No additional inform exiting the facility as to monitor Resident #6, provide monitoring for medications Geodo Resident #6 was ad 09/24/15. Diagnose anxiety, depression peripheral vascular dementia, Parkinson	roquel, could not be located in The surveyor reviewed al record with the UM. The at the specific physician order he UM stated that she did not eyor was asking for. The that when a resident is ropic medication the facility at specific behaviors, effects and other interventions cility staff. The UM stated, eat."  3:30 p.m. the survey team strator (Adm), Director of effect (CNO), Nurse (QAN), Chief Financial attenance Director (MD) and notified the Administrative facility staff failed to monitor chotropic drug use. The effect AT that Resident #1 was and that review of the clinical duce psychotropic drug use, the facility staff failed to for the antipsychotic in and Seroquel.  Imitted to the facility on sincluded but not limited to anemia, hypertension, disease, malnutrition, ease, end stage renal disease,	F3	29			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495374	B. WING			05/11/2016
NAME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE ZIP CODE	
MOUNTA	IN VIEW REGIONAL	MEDICAL CENTER		310 THIRD ST NORTON, VA	A 24273	
(X4) ID PREFIX TAG	/FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG	x (EACI	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 329	Continued From pa		F	29		
	an ARD (assessme	DS (minimum data set) with intreference date) of 02/04/16 tas 01 out of 15 in Section C, is is a quarterly MDS.				
	05/11/16. It contains summary dated 04/ "Quetiapine tab 50/ bedtime For: Serod 60mg 1 capsule PC supper For: Geodorecord contained no monitoring for the in the unit manager at	al record was reviewed on ed a signed physician's order /30/16 which read in part mg 1 tablet PO (by mouth) at que!" and "Ziprasidone Cap o with breakfast and with on". The Resident's clinical of evidence of behavior nedications. Surveyor asked bout the lack of monitoring and did that they had never done				
	brought to the atter	he lack of monitoring was attention of the administrative staff of 05/11/16 at approximately				
F 425 SS=E	No further information was provided prior to exit. 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH			25 Pharmacy v	vill be notified	6/24/16
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn law permits, but on supervision of a lice	ovide routine and emergency als to its residents, or obtain sement described in part. The facility may permit all to administer drugs if State by under the general ensed nurse.		orders by fa is not reciev charge nurs primary car- will contact	ot of new medication ax. When a medication wed within 16 hrs, the se will be notified by the nurse. The charge the pharmacy to inquest.	he nurse
	(including procedur	es that assure the accurate		about the m	nedication.	

PRINTED: 05/26/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			WALL O ATT OLIDATIV
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495374	B. WING		05/11/2016
	PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP C 310 THIRD STREET, NE NORTON, VA 24273	ODE
(X4) ID PREFIX TAG	(EACH DESIGIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
F 425	The facility must en	, dispensing, and drugs and biologicals) to meet esident.  apploy or obtain the services of sist who provides consultation a provision of pharmacy	F	If medication is still not available in order. All me unavailable by pharmacy with monitored to ensure medicalternative, or change in or	or alternative adications deemed will be cation, rders is received
	by: Based on staff interest and facility documes that the facility staff ordered medication administration for 3 survey, Resident #8. The Findings Includes 1. For Reside ensure that physicial Remeron were available Remeron were available and interest and originally admitted 2/27/13. Admitting not limited to: protein himself of the most current in the control of the most current in the clinic with an Assessmer 3/31/16. The facility had a Countitive St.	ent #1 the facility staff failed to an ordered Zinc Oxide and ilable for administration.  90 year old female who was on 9/2/12 and readmitted on diagnoses included, but were in calorie malnutrition, anemia, hypertension, adult failure to s, dementia, chronic kidney		within 24 hrs per policy. Omenitor pharmacy compliants  Numerator=number of inition not received or alternative per policy  Denominator=Number of ordered	ance weekly.  itial medications  e not received

nursing care with Activities of Daily Living (ADL's).

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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ŀ			455574	B. WING		05	/11/2016
l	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
l	MOUNTA	IN VIEW REGIONAL I	MEDICAL CENTER		310 THIRD STREET, NE		
I	111001111	THE PROPERTY OF THE PARTY OF TH	WENT OF THE PROPERTY OF THE PR	ſ	NORTON, VA 24273		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 425	Continued From pag	g <b>e</b> 16	F 4:	25		
	i		7:55 a.m. the surveyor				
			1's clinical record. Review of				
			oduced signed physician				
		orders. Signed phys	ician 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						
			evening before bedtime.				
			the clinical record produced				
			lication Administration				
			eview of the March 2016				
			that the physician ordered				
		2/10 Oxide was not a 3/28/16. The March	ivailable for administration on				
			Remeron was not available				
		for administration on					
			3:15 a.m. the surveyor				
			ager (UM), who was a				1
			N) that the facility staff				
			sident #1's physician ordered				
			eron were not available in				
			rveyor reviewed Resident ith the UM. The surveyor				ľ
			fic order for the Zinc Oxide		14		
			surveyor then reviewed the				}
			ith the UM. The surveyor				
	1		acility staff documented on				
	1.1	March 25, 2016 that I	Resident #1's physician				1
		ordered Remeron wa					
			surveyor also pointed out				
			ocumented on 3/28/16 that				
		he physician ordered					}
			ration. The surveyor asked				
		itated, "Yes."	ckup pharmacy and the UM				
			:30 p.m. the surveyor				

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	J	CALIFTELICTION	(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		COMPLETED
		495374	B. WING		05/11/2016
	PROVIDER OR SUPPLIER	MEDICAL CENTER	310	EET ADDRESS, CITY, STATE, ZIP CODE THIRD STREET, NE RTON, VA 24273	
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	"Unavailable Medic procedure read in procedure read in procedure read in procedure resident in the nurse for dispensing from may result from the out of stock of a paramufacturer's show situation may be personal to be manually to the nursing staff of the staff of the nurses (Don), Chousity Assurance Officer (CFO), Mai UM. The surveyor Team (AT) that the that physician order and Remeron, were for Resident #1. No additional information that physician order than physicia	y policy and procedure titled, rations." The policy and part on, a medication ordered for a sing facility may be unavailable the 24 hour pharmacy. This a pharmacy being temporarily inticular product, a drug recall, ortage of a drug, or the armanent because the drug is factured.  The pharmacy for the resident their needs. If the shortage ent's immediate need of the medication box for availability of the pharmacy for availability of the pharmacy for availability of the shortage ent's pharmacy ent's phar	F 425		
1	, the medication, by	Herrore corned (191			

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i		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			TE SURVEY MPLETED
			495374	B. WING			05	/11/2016
į		PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, 310 THIRD STREET, NI NORTON, VA 24273		1 00	11/2010
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD ICED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 425	a) The facility staff f	ge 18 s available for administration. failed to ensure Resident #2 ant, Effexor, available for	F 42	25			
		with diagnoses of str congestive heart failing dementia, hypertens osteoporosis, and hy The current significal with a reference date resident with short ar The resident was ass assistance of 1 perso bathing, dressing, toil The clinical record was ordered Effexor 75mg night for 1 week begin						
	1 1 7 7 8 8 8 8	March 2016 was revienitials indicating the rife nurse documente for 3/10/16,3/11/16, and as not in the drawer axed on 3/10. The nifexor 75mg was "sti						
	n	). The facility staff fail nedication, Synthroid	88mcg (for hypothyroidism)					

CENTER	(3 LOIL MILDICALL	G MLDION OF CERTIFICE	T			(X3) DATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ITIPLE C	ONSTRUCTION	COMPLETED
		495374	B. WING			05/11/2016
	PROVIDER OR SUPPLIER	MEDICAL CENTER		310 7	ET ADDRESS, CITY, STATE, ZIP CODE THIRD STREET, NE TON, VA 24273	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 425	Continued From pa	ge 19	F	125		
	physician order for	was reviewed and revealed a Levothyroxin tab 88mcg 1 ) before breakfast for: g 4/6/16.				
	May 2016 was reviewed initials indication administered on 5/3 nurse documented	ministration record (MAR) for ewed. The nurse had circled g the Synthroid had not been 5, 5/6, 5/7, 5/8, and 5/9. The on the back of the MAR the ilable on those dates for				
	approximately 10:0	stated on 5/11/16 at 0 a.m. the facility had a back for long term care residents could be called after hours.				
	finding during a me 5/11/16 at 3:30 p.m. 3. The facility staff i	team was informed of the eting with the survey team on . failed to ensure medication dministration for Resident#8.				
	with diagnoses of	dmitted to the facility on 2/8/16 sinusitis, malnutrition, anxiety, a, deep vein thrombosis, ltis, dementia, and				
	with a reference da resident with a cog resident was asses assistance of 1 per in room, dressing, 0	nge Minimum Data Set (MDS) te of 4/11/16 assessed the nitive score of "14" of "15". The sed requiring extensive son for transfers, ambulation toileting, hygiene, and bathing.				
	The clinical record	was reviewed. The record				

CENTER	13 FUR INIEDICARE	O MEDICALD OF MACE							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495374	B, WING	à			05/	11/2016	
	PROVIDER OR SUPPLIER	MEDICAL CENTER		310	EET ADDRESS, CITY, STATE, ZIP C THIRD STREET, NE RTON, VA 24273	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
	for, "Singulair 10mg directed for seasor The April 2016 med (MAR) was reviewe Initials on the front of on the back of the M given Singulair med	an written order dated 4/8/16 If q hs (every bedtime) as hal allergies, sinusitis".  Idication administration recorded, The nurse circled her of the MAR and documented MAR for 4/8/ and 4/9, "not available".	F	425					
	The administrative team was informed of the finding during a meeting with the survey team on 5/11/16 at 3:30 p.m. 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.		Charge nurse will review 6/10/16 all diagnostic orders daily for completion. Charge nurse will verify daily that results						
j	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.			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.					
	09/24/15. Diagnose anxiety, depression, peripheral vascular dementia. Parkinsol	mitted to the facility on s included but not limited to anemia, hypertension, disease, hyperlipidemia, n's disease, malnutrition, ease, end stage renal disease,		writte	ominator=Number of d				
	The most recent MD an ARD (assessme)	OS (minimum data set) with nt reference date) of 02/04/16							

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CENTE	KO LOW MEDICAKE	A MILLIONIO OLIVATOLO			OHID HO. GOOD GOO			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495374	B. WING		05/11/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MOUNTA	AIN VIEW REGIONAL	MEDICAL CENTER		310 THIRD STREET, NE NORTON, VA 24273				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION			
F 502	cognitive status. Th	as 01 out of 15 in Section C, is is a quarterly MDS.	F 50	02				
	05/11/16. It contained dated 02/22/16 while x-ray) CMP (compred CBC (complete block with culture and sernot locate the result surveyor asked the	al record was reviewed on ed a signed physician's order ch read in part "CXR (chest ehensive metabolic panel) od count) U/A C&S (urinalysis estivity)". The surveyor could is for the U/A with C&S. The unit manager if she could ab results and she could not.						
	brought to the attent	missing lab report was tion of the administrative staff 05/11/16 at approximately						
F 514 SS=D	No further information was provided prior to exit. 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE			4 I of residents physician order eets will be reviewed monthly	6/29-16			
	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.			by designated nurse and checked				
	information to identification resident's assessment services provided; the	ning conducted by the State;	by nu ve	Iministered via route designate the MD order, the primary can urse will contact MD for clarifica rification and other options for Iministration.	re ation/			
j	This REQUIREMEN	T is not met as evidenced						

Event (D:99DQ11

OFIALE	TO LOIT MEDICALLE	C HILDIOING CETTORS	1				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTI	ION		E SURVEY  IPLETED
l		495374	B. WING	;		05/	11/2016
	(EACH DEFICIENC)	MEDICAL CENTER  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG	310 THIRD STRI NORTON, VA PROV IX (EACH I		ULD BE	(X5) COMPLETION DATE
F 514	by: Based on staff intereview, it was deterfailed to ensure a crecord for 2 of 12 Resident #1 and Resident #1 and Resident #1 and Resident #1 ensure complete ar Sheets (POS's) and Records (MAR's). Resident #1 was a soriginally admitted of 2/27/13. Admitting not limited to: protein hemiplegia, anxiety thrive, osteoporosis disease and osteoa The most current Milocated in the clinical with an Assessment 3/31/16. The facility had a Cognitive Surstaff also coded than ursing care with Acon May 11, 2016 at reviewed Resident the clinical record porders. Signed POS limited to: "NPO (no Only. Oxycodone Teby mouth EVERY 12 Strength**8719225F Lorazepam Tab 0.51 (every) 6 hours PRN 7279744RX# Start: 500mg 1 tablet PO pain/elevated Temp	rview and clinical record mined that the facility staff complete and accurate clinical esidents in the sample survey. Seident #6.  1 the facility staff failed to ad accurate Physician Order Medication Administration  90 year old female who was on 9/2/12 and readmitted on diagnoses included, but were n calorie malnutrition, anemia, hypertension, adult failure to dementia, chronic kidney rthritis.  Inimum Data Set (MDS) at record was a Quarterly MDS at Reference Date (ARD) of a staff coded that Resident #1 mmary Score of 1. The facility to Resident #1 required total trivities of Daily Living (ADL's).  7:55 a.m. the surveyor #1's clinical record. Review of roduced signed physician thing by mouth) Ice Chips ab 10MG ER '2 Tabs' (20mg) 2 Hours **Note Dosage RX# Start: 04/19/16.  mg 1 tablet po (by mouth) Q I (as needed) For: Ativan 04/08/15. MAPAP Tab	F	physician ord	number of resident ler sheets =number of reside		odated

		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
I			495374	B. WING	White the state of	05/11/2016
		PROVIDER OR SUPPLIER	MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 THIRD STREET, NE NORTON, VA 24273	,
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
		sources** 5226605F Ondansetron Tab 4 PRN For: Zofran 75 (diagnoses): Nausea Continued review of the Comprehensive the CCP revealed a Resident #1 was on On May 11, 2016 at the Unit Manager (U Nurse (RN), how Re medications. The Ul received her medicat (percutaneous endos surveyor notified the failed to ensure comp The surveyor notified Resident #1's medicat tube: however, some ordered to be admini- surveyor reviewed the Surveyor reviewed the UM. The surveyor Resident #1's medicat given by mouth: howe pos's and the May a the UM. The surveyor Resident #1's medicat given by mouth: howe condered to be NPO as surveyor also asked i Comfort Care and the surveyor notified the face plan for Comfort did not contain an ord on May 11, 2016 at 2 delivered a physician fo/26/13 that read in part esterday with (name calliative care" (sic	RX# Start: 11/22/13. mg 1 tablet po Q4-6 hours 59794RX Start: 06/03/15 DX a and Vomiting." (sic) the clinical record produced Care Plan (CCP). Review of care plan that identified that Comfort Care. 8:15 a.m. the surveyor asked M), who was a Registered sident #1 received her M stated that Resident #1 tions by PEG tube scopic gastrostomy). The UM that the facility staff plete and accurate POS's. If the UM that most of ations were ordered via PEG of her medications were stered by mouth. The e clinical record with the UM. ed the physiclan signed and April 2016 MAR's with or pointed out that some of ations were ordered to be ever, Resident #1 was on a UM stated, "Yes." The UM that the CCP included a Care, however, the POS's ler for Comfort Care. 30 p.m. the UM hand telephone order dated art "I discussed care withheld). Pt (patient) is ) The UM stated that she for palliative care in medical	F 51	4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495374	B. WING			05/11/2016	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW REGIONAL MEDICAL CENTER				310	EET ADDRESS, CITY, STATE, ZIP CODE THIRD STREET, NE RTON, VA 24273		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	i ID PREFI TAG	x !	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	met with the Admini Nurses (DON), Chic Quality Assurance Nofficer (CFO), Main UM. The surveyor ream (AT) that the complete and accur Resident #1. No additional informexiting the facility as to ensure complete MAR's for Resident #6. For Resident #6 ensure the physicia included on the POS summary).  Resident #6 was accorded the POS summary.  Resident #6 was accorded the Arkinson coronary artery diseand thyroid disorder. The most recent ME an ARD (assessmel coded the Resident cognitive status. This Resident #6's clinical coded the total the content and the summary provides the coded the status. The most recent POS the most recent POS the coded the summary possible	strator (Adm), Director of strator (Adm), Director of strator (Adm), Director of strator (QAN), Chief Financial stenance Director (MD) and sotified the Administrative state POS's and MAR's for stown was provided prior to stown the facility staff failed and accurate POS's and #1. The facility staff failed to so order for "lap buddy" was so (physician's order mitted to the facility on sincluded but not limited to anemia, hypertension, disease, hyperlipidemia, n's disease, malnutrition, sase, end stage renal disease.	F	514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495374	B. WING			05/	11/2016
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 310 THIRD STREET, NE NORTON, VA 24273			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	0 8E	(X5) COMPLETION DATE
F 514	Continued From pa	ge 25	F 5	14			
	not on the POS.						
	attention of the adm	sing order was brought to the ilnistrative staff during a 3 at approximately 1530.					
	No further information	on was provided prior to exit.					